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ABSTRACT

In Australia, there is increasing attention being paid to the promotion of mental health and the prevention of serious mental disorder by policymakers, funders, academics and service providers. This has required a shift in thinking to focus on health and well being, not just on illness and treatment. The National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000 is a national framework endorsed by the National Mental Health Working Group and the National Public Health Partnership. The Action Plan 2000 identifies the important relationship between work and emotional and social well being and regards it as a priority area for action. The present edited volume on mental health and work seeks to address this significant issue from a variety of perspectives. It is hoped that this volume will increase knowledge and understanding of the inextricable relationship between work and mental health and influence the development and implementation of effective strategies to promote mental health and prevent mental disorders. The original intent for this book was to consider the workplace as a target for universal approaches to mental health promotion and to record a range of successful national programs. What emerged from discussion was a need to consider work more broadly than workers and workplaces, and to therefore consider mental health and its promotion in the context of work in more depth. What has resulted is a rich archive of contemporary issues surrounding work in Australia, as well as seminal work from abroad. (Contains references at the end of each chapter.) (GCP)

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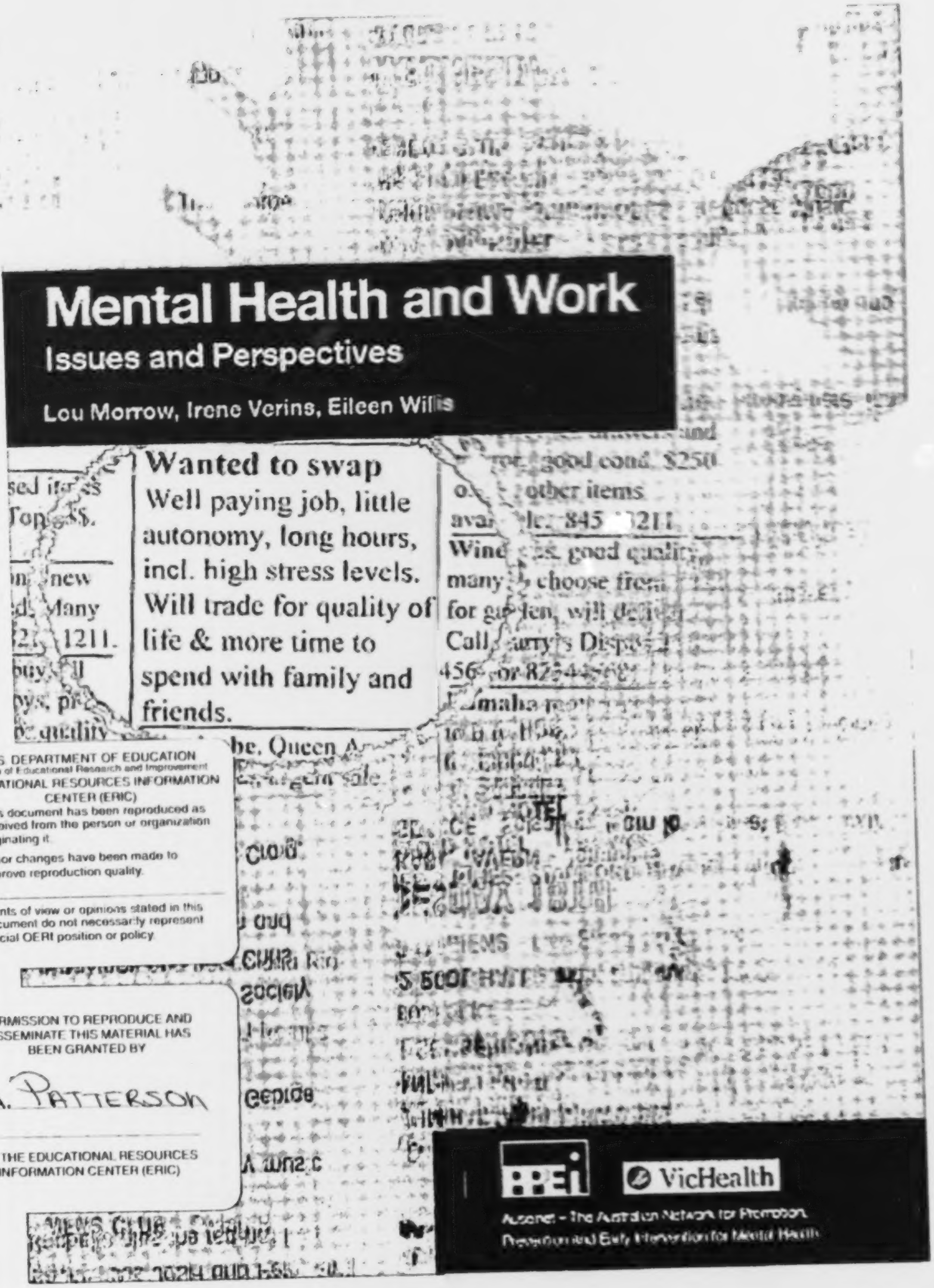
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Mental Health and Work

Issues and Perspectives

Lou Morrow, Irene Verins, Eileen Willis

Auseinet – The Australian Network for Promotion, Prevention and Early Intervention for Mental Health
VicHealth

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Mental Health and Work

Issues and Perspectives

Edited by
Lou Morrow
Irene Verins
Eileen Willis

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Foreword

In Australia, there is increasing attention being paid to the promotion of mental health and the prevention of serious mental disorder by policymakers, funders, academics and service providers. This has required a shift in thinking to focus on health and wellbeing, not just on illness and treatment. The *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000* is a national framework endorsed by the National Mental Health Working Group and the National Public Health Partnership. It is a joint Commonwealth, State and Territory Initiative under the Second National Mental Health Plan, which provides a policy framework for the promotion of mental health and prevention and early intervention for mental health problems and mental disorders. The Action Plan 2000 identifies the important relationship between work and emotional and social wellbeing and regards it as a priority area for action.

Auseinet (The Australian Network for Promotion, Prevention and Early Intervention for Mental Health) is a national project funded by the Commonwealth Department of Health and Ageing to support the development and implementation of activities and initiatives that address mental health promotion and the prevention and early intervention for mental disorder.

The present edited volume on *Mental health and work: issues and perspectives*, commissioned by Auseinet and developed in collaboration with VicHealth (the Victorian Health Promotion Foundation), seeks to address this significant issue from a variety of perspectives. Identity, meaning and participation are critical social and emotional dimensions of work. It has meaning for all individuals in society. As a consequence, work directly impacts on *whole of community* emotional and social wellbeing.

It is our hope that this volume will increase knowledge and understanding of the inextricable relationship between work and mental health and influence the development and implementation of effective strategies to promote mental health and prevent mental disorders.

The original intent for this book was to consider the workplace as a target for universal approaches to mental health promotion and to record a range of successful national programs. What emerged from discussion, and was reinforced by a seminar hosted by VicHealth in

Melbourne in 2001, was a need to consider work more broadly than workers and workplaces, and to therefore consider mental health and its promotion in the context of work in more depth. What has resulted is a rich archive of contemporary issues surrounding work in Australia, as well as seminal work from abroad.

We congratulate Lou Morrow for all her work in bringing together such a wide group of authors, and for seeing this work through with the help of co-editors Irene Verins and Eileen Willis. We commend it to you the reader.

Professor Graham Martin
Director, Child and Adolescent Psychiatry,
University of Queensland
National Adviser to Auseinet

Jennie Parham
National Project Manager
Auseinet

Acknowledgements

The editors would like to thank all the contributors for agreeing to be part of this project and for maintaining their enthusiasm. Special thanks to Auseinet national project manager Jennie Parham for unequivocal commitment throughout the project and funding for the publication, to Professor Graham Martin for initially sewing the seeds from which the book came to fruition, and to Auseinet team members for their ongoing support. We thank VicHealth CEO, Dr Rob Moodie and the staff of VicHealth for their contribution to, and dissemination of this publication, and ongoing commitment to the theory and practice of mental health promotion. Many others have assisted with the development, creative aspects and publication knowledge required to put together a volume of this kind. The editors thank Carolyn Emden and Margaret Bowden for their editorial expertise, layout and attention to detail, Simon Kneebone for his perceptive representations of mental health and work in his cartoons, the Student Project Team for Images and eResources for their creative talent and cover graphic design, Leigh Roeger for his statistical oversight and the Inprint Design team, especially Lee-anne, Natalie and Andrew.

Auseinet especially thanks Eileen Willis (Flinders University) and Irene Verins (VicHealth) for their editorial and creative involvement over many months.

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Employee Health Committee - Upper Hume Community Health Service Victoria. The members of the committee are Shandell Blythe, Carolyn Ellis, Loretta Foster, Frank Johnson, Paula Mobach and Tanya Paech. They are all employed in the community development and service delivery initiatives of the regional health service and together developed the article about their experiences of the process of establishing the committee.

Bernadette Fallon has worked in employment development for 18 years in government and community sectors. At the time of writing she was employed on the 'Working for Ages' project, an initiative of the Victorian Equal Opportunity Commission, Department of Human Services and VicHealth. She has a special interest in employment for particularly disadvantaged groups and has worked on programs for young Aboriginals and Torres Strait Islanders, people with disabilities, people from culturally and linguistically diverse backgrounds and young people.

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The Rumbalara Community members who contributed their time to developing a piece for this book are listed in the chapter by **Rosemary Hoban**. They have all continued over the years to give their time to build and maintain a holistic program that promotes cultural strength, Koori health and reconciliation – which is Rumbalara as we know it now.

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Introduction

> Our view is that mental health is a decent work issue
>
> Juan Somavia, ILO Director-General

It is now widely recognised that social and environmental conditions, and particularly relative social disadvantage, have significant effects on mental health and illness. Economic participation through access to decent, meaningful work, and democratic and social participation through connectedness, belonging and freedom from discrimination and violence, are seen as critical to the mental health and wellbeing of individuals, organisations, communities and nations. The construction of relevant and sustainable mental health promotion policy and programs requires a perspective which regards and values work and workplace mental health promotion as part of a civil society, not only as good business practice. This will also require acceptance at all levels of society of the connection between access to meaningful, safe work, healthy jobs and mental health.

Increased productivity, flexibility and efficiency, and change and competition, are constant features of most workplaces in the globalised marketplace. The pressure to perform within financial restraints in work environments of constant uncertainty and shifting priorities has focused the attention of both public and private sector alike on economic capital, thereby marginalising the value of human capital. There is evidence in Australia of longer working hours with fewer available full-time jobs, while others are either underemployed, increasingly in part-time work, in poor quality work not fit for a machine, or unemployed. Information technology means organisations can increase their wealth without creating jobs, indeed by eliminating positions.

While the workplace is both contributor and threat to wellbeing, *being in* the workforce with access to decent, meaningful work is a dimension of national life and expectation from which many citizens remain excluded, with poorer health outcomes and an inequitable burden of disadvantage. Unemployment, as a by-product of economic and fiscal policy, is an accepted feature and 'economic tool' of deregulated market economies, accomplished most potently via discriminatory and inflexible practices and social structures, which exclude certain individuals and groups. Exclusion from work via unemployment is experienced most drastically in the lives of people who have a mental illness. The stigma associated with mental illness is pervasive and persistent.

These characteristics represent dominant cultural ideas and pursuits, organisational and institutional cultures, and career structures patterned on values which have increasingly ignored the emotional and social aspects of community and family life.

On the other hand, the workplace provides an important opportunity for mental health promotion and prevention of mental ill health, both in terms of access to a large proportion of the adult population and also as a site for encouraging developments to improve the health of communities. However, despite growing awareness around the world and the estimates of many OECD countries of the burgeoning economic cost of work-related illness and injury to national productivity, a new report from the Health and Safety Executive in Britain paradoxically points to a significant decline over the last ten years in occupational health services. Fewer workers in Britain now have access to health support at work (declined by nearly 50% since 1990), and fewer businesses (only 3% of all UK organisations) provide occupational support to help prevent work related illness (HSE, 2002).

In its landmark mental health report in 2001, the World Health Organization reiterated its now well-known prediction for a dramatic rise over the next 20 years in mental illness. Major depression, which has been increasing over the last decade, is already the leading cause of disability globally and is predicted to rise alarmingly over the next two decades (WHO, 2001). There is no doubt that work per se, its changing nature and consequences, and workplaces have been, and will continue to be significant contributors to this rise without important changes in priority and direction.

This publication, a collaboration between Auseinet and VicHealth (the Victorian Health Promotion Foundation), was initiated, funded and published by Auseinet – The Australian Network for Promotion, Prevention and Early Intervention for Mental Health. Auseinet is a national project funded under the National Mental Health and National Suicide Prevention Strategies, based at the Flinders University of South Australia.

In joining with VicHealth to produce this edited collection, Auseinet recognised the Victorian Health Promotion Foundation and CEO Dr Rob Moodie as drivers of the momentum and innovation in health promotion in Victoria and influential nationally. Auseinet's early development discussions for the publication determined the need to include understandings about structural issues related to work/ employment which explicitly link work and the social determinants of health rather than being only limited to workplaces and workers. In 1998 the Victorian Health Promotion Foundation identified mental health promotion as a key area for action over the ensuing three-year period. As a result, VicHealth developed its *Mental Health Promotion Plan 1999-2002*, focusing on three determinants of mental health – increasing connectedness and belonging; reducing discrimination; and maximising economic participation. Through the development and implementation of a mental health promotion plan, VicHealth aimed to focus on improving the social, physical and economic environments that determine the mental health of populations and individuals (VicHealth, 1999).

The intention of this edited collection was to explicitly engage the social, environmental and ethical dimensions of work and wellbeing. The *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health* (Commonwealth Department of Health & Aged Care, 2000) and VicHealth's *Mental Health Promotion Plan 1999-2002* have provided the guiding documents in bringing together this joint publication.

And so to the contributions. While it was the editors' hope for the publication to elaborate the terrain which constitutes the field of mental health and work, we cannot claim that the chapters represent or draw from the entire diversity of contemporary thought in this area. That is not surprising. To date, and reflected to an extent in some contributions to the book, much attention and research in this field has narrowly focused on individuals. One effect of this narrow approach has been to minimise attention to, if not invisibilise, organisational practices and characteristics or wider structural/societal factors which are in themselves detrimental to mental health, for instance discrimination, intolerance of difference, and fundamental abuses of human rights and human dignity in the context of employment.

However, importantly, what are elaborated here are key opportunities for mental health promotion and prevention of mental ill health related to work, workplaces and communities. What is also clearly apparent in a number of contributions are the levels of operation at which these opportunities must be pursued for an effective public health response – not only at the individual, local or business and organisation levels, but also at the level of whole of community. The chapters reflect contributions and common ground from Australia, New Zealand, Italy and the United Kingdom. The structure of the book was determined by the nature of the contributions, organised as sections around the themes of the context, identity, safety, emotions and the last section, people, places and processes. Each section is introduced by the editors. We hope you enjoy the collection and find it useful.

Lou Morrow, Irene Verins and Eileen Willis
Editors
August 2002

References

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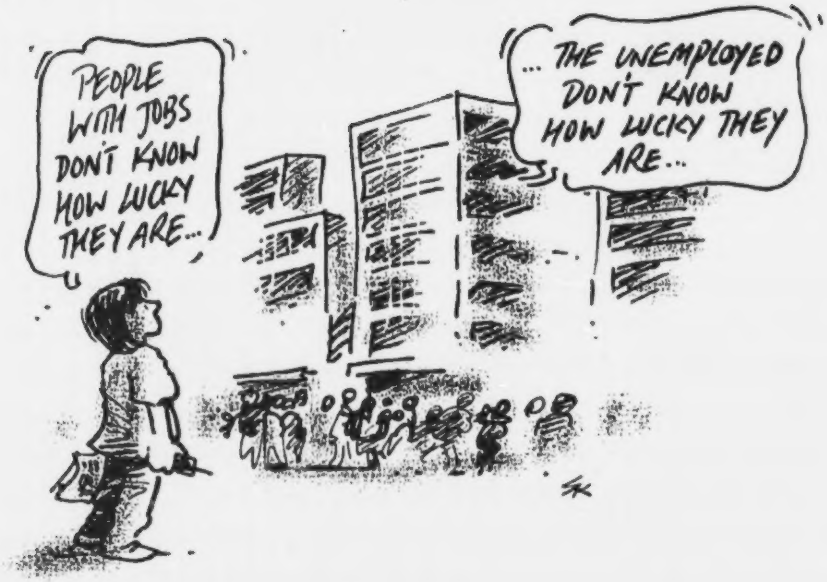
Section I
The context

Some twenty years ago a book about mental health and work might have appeared incongruous to the curious reader. This is not so in these early years of the 21st century when most people have either experienced stress or emotional turmoil in their workplace or have friends or relatives who have undergone the experiences of downsizing, outsourcing or corporate takeovers. We now recognise that workplaces must be significant to our mental health, given the time we spend at work and the effort we invest in paid employment. More importantly, we recognise that few workplaces in Australia, or in other developed economies, have escaped the dramatic structural and cultural changes accompanying monetary, trade and labour deregulation. The flexible workplace and new managerial practices of benchmarking, best practice, performance appraisals and *Just in Time* approaches to productivity and efficiency gains have not been achieved without cost to individual workers and their families.

The psychology behind these reforms is the basis of the first chapter in this collection. Maureen Dollard and Tony Winefield's investigation of *overemployment, underemployment and healthy jobs* contextualises the dramatic shifts in working life over the last decade, illustrating the clear links between mental health and wellbeing, and the social determinants of health such as socioeconomic status, individuals' personal control over their working day and social connectedness. Their detailed account of the psychological literature on workplace stress, burnout, social isolation, underemployment and overemployment confirms both the researched and anecdotal accounts of epidemiologists, industrial relations commentators, occupational health and safety officers and workers alike. Dollard and Winefield's review of the variety of theoretical approaches to stress and work points clearly to factors other than personal problems or the individual pathologies of dissatisfied workers. Wellbeing at work is contingent on some level of personal control and social support. This is an optimistic analysis coming from within the discipline of psychology. It points clearly to the possibilities for intervention. A number of the papers in this collection outline some of these health-promoting possibilities.

This first section in this book also includes one of the three poetic reflections by Peter Waterhouse. This is his poem *Dear Director*. We think it captures many of the frustrations experienced by the anxious worker ready to please in a climate of precarious employment. The most obvious one Peter points to is the constant need to re-make the self in order to meet the job description. Situated at the end of this section, we think this poem makes a neat link between Dollard and Winefield's overview and the first of our four sections, 'Work and identity'.


PEOPLE WITH JOBS DON'T KNOW HOW LUCKY THEY ARE...
... THE UNEMPLOYED DON'T KNOW HOW LUCKY THEY ARE...

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1 Mental health: overemployment, underemployment, unemployment and healthy jobs

Maureen F. Dollard and Anthony H. Winefield

Introduction

Globalisation and regional economic imperatives have no doubt led to modern work environments increasingly characterised by 'too much work', 'not enough work' and 'no work' rather than optimal 'healthy-productive' work. Besides negative implications for national economies, there is a strong belief that mental health problems and stress-related disorders are the biggest overall cause of premature death in Europe (WHO 2001; Levi, 2002). Income inequality arising from such disparate work states seems to have negative health consequences for all members of society as social cohesion that characterises healthy egalitarian societies progressively breaks down (Wilkinson, 1996).

This paper explores the various work states, and draws upon a range of work stress and unemployment theories and empirical evidence to describe possible relationships between the meaning of work, work states, their features, and mental health. It also explores the 'holy grail': the balance between healthy work and productivity.

Mental health and work

There is increasing awareness of the fundamental importance of mental health in a range of life arenas – for physical health, quality of relationships, family life, work and education. The focus of this paper is the link between work and mental health. The Australian National Action Plan for Promotion, Prevention and Early Intervention for Mental Health (Commonwealth Department of Health & Aged Care, 2000 p20) noted 'there is evidence of significant increase over recent years in the level of reported workplace stress and an associated increase in related mental health problems and mental health costs'.

The term 'mental health' is often used interchangeably with social, emotional, and spiritual wellbeing (Lehtinen, Riikonen & Lahtinen, 1997). Recently, the Victoria Health Promotion Foundation proposed a new definition of mental health (VicHealth, 1999) as:

> ...the embodiment of social, emotional and spiritual wellbeing. It provides individuals with the vitality necessary for active living, to achieve goals, and to interact with one another in ways that are respectful and just (p4).

Mental health covers broadly the areas of emotions, behaviours, relationships and cognitions. For example, a person may be physically healthy but have difficulty with aggressive behaviours.

A particular definition of health adopted by the Department of Health in the United Kingdom, which embodies emotional wellbeing centrally and is understandable by most people is 'being confident, and able to cope with the ups and downs of life' (Stewart-Brown, 1998, p1608).

Social determinants of mental health

It has long been recognised among researchers that there are a number of social determinants important in the development and maintenance of mental health. A landmark publication by the World Health Organisation, *Social Determinants of Health* (Wilkinson & Marmot, 1998) presents a summary of evidence-based findings linking social determinants such as social status, stress, early life, social exclusion, work, unemployment, social support, addiction, food and transport, and health in its broad sense.

Based on such considerations, the European Council of Ministers (15th Nov. 2001) concluded that:

> stress and depression related problems ... are of major importance ... and significant contributors to the burden of disease and the loss of quality of life within the European Union.

Further, they underlined that such problems are:

> common, cause human suffering and disability, increase the risk of social exclusion, increase mortality and have negative implications for national economies (cited in Levi, 2002, piii).

The work stress and unemployment literature is therefore very important to help understand the link between work and mental health.

Income inequality

Associated with the growing gap between 'good' and 'bad' jobs has been an increase in income inequality. Wilkinson (1996) has argued from international epidemiological statistics that increased income inequality has negative health consequences (reduced life expectancy) for all members of society – both rich and poor – and he proposes the underlying mechanism for this is the breakdown of social cohesion that characterises 'healthy egalitarian societies'. In such societies, according to Wilkinson, there is 'a strong community life'; and 'people are more likely to be involved in social and voluntary activities outside the home' (p4).

Wilkinson's conclusions have been criticised by Catalano (1998) who argues the epidemiological case is weak and that the main cause of concern should be growing economic insecurity, even among the more affluent. He points out that a 1996 USA survey found that 37% of American households reported they were 'economically insecure' and 43% with an annual income of more than $50,000 feared that one of their members would be laid off in the next three years (Catalano 1998, p168). Another criticism of Wilkinson's thesis is that he puts forward no evidence, other than anecdotal, to support the view that increased income inequality leads to a breakdown in social cohesion.

Employment has also become more precarious as workers are employed increasingly on contract (Schalk, Heinen & Freese, 2001; Winefield, Montgomery, Gault, Muller, O'Gorman, Reser & Roland, 2002) and the permanent job itself has become more insecure, leading to predictions that by 2020 a quarter of the workforce will be in non-traditional employment arrangements (Judy & D'Amico, 1997).

Developing identity

Work has long been regarded as an important facet to mental health and the developing identity (Erikson, 1982). It has been argued that employment (even bad jobs) can provide latent benefits, including:

- a time structure for the waking day
- regular contact with people outside the nuclear family
- involvement in shared goals
- a sense of identity
- enforced activity (Jahoda, 1982).

Extensive research has shown that job loss results in a significant deterioration in affective wellbeing (Cobb & Kasl, 1977; Linn, Sandifer, & Stein, 1985) and re-entry leads to significant improvements in mental health (Warr & Jackson, 1985; Payne & Jones, 1987). However, researchers also argue that satisfaction with employment is the key ingredient differentiating employment and unemployment experiences. Being satisfactorily employed enhances psychological growth and self-esteem, but being unsatisfactorily employed is detrimental to psychological health and is psychologically as bad as being unemployed (Winefield, Tiggemann, Winefield & Goldney, 1993; Winefield, 2002). Clear empirical links between psychological and physical ill health and work have challenged the taken-for-granted assumption about the positive mental health benefits of work.

Current work context: psychological and health costs

There are major changes occurring today in various aspects of work that are impacting on the experience of work in Australia:

1. The workforce is increasing in diversity and complexity. The domination of the workforce by men is declining and there is an increase in the proportion of women and people from ethnic minorities in the workforce. The Australian population is becoming increasingly educated. School retention rates have increased dramatically within the last two decades.

2. There is a relative decrease in the number of full-time jobs and a relative increase in the number of part-time jobs available. In addition, there is an increasing reliance upon casual and contract labour.

3. The increased number of women participating in the workforce means there is also an increase in dual-career couples.

4. Those employed full-time are working longer hours according to the Australian Bureau of Statistics (2002). It remains to be seen whether this trend can be reversed as in France, the world's fourth largest economy, where the government recently enacted laws restricting the working week to 35 hours. (Even if the French succeed, it is difficult to see how overworked professionals whose working hours are not recorded might benefit).

5. There is a shrinking supply of paid work compared to the growing numbers of people seeking it. No matter how much national and global economies attempt to grow there appear to be inevitable environmental limits to such growth, as well as recent demonstrations that economic growth occurs fitfully and unreliably, and does not always result in a proliferation of job opportunities.

Changes in the workplace

The nature of the workplace is changing rapidly with increased demands from globalisation of the economy and the rapid development of communication technology (Cascio, 1995b; Schabracq & Cooper, 2000). Computers, telecommunication systems, robotics and flexible manufacturing operations have led to a decreasing reliance on direct human labour, while at the same time productivity is increasing (Winefield, Montgomery *et al.*, 2002). Routine tasks are increasingly being performed by automation, freeing employees to take on more varied and challenging tasks. This means that employees' skills are becoming obsolete more quickly, necessitating an increasing focus on continuing training and education.

Technological changes have also led to an increasing amount of poor-quality work – 'work not fit for a machine to do' – that is unsatisfying, offering low pay, low job security and unreliable hours. This 'labour work' such as house-cleaning, waitressing and casual clerical work is often undertaken by women and cultural minorities (Winefield, Montgomery *et al.*, 2002). Many jobs in the fast expanding service sector require workers to adopt a smiling and friendly manner to consumers, which makes demands similar to those involved in 'emotional work'.

Under the pressure of economic rationalism, workforce numbers have been reduced, although the amount of work to be done often has not. *Overemployment* means that many workers in full-time jobs are experiencing increased pressure and faster pace (Bousfield, 1999), increased workload (Townley, 2000), longer shifts and longer hours (Heiler, 1998; Winefield, Montgomery *et al.*, 2002), as well as demands for high organisational performance (Kendall, Murphy, O'Neill & Bursnall, 2000).

Work-related risks to health and family functioning

Two apparently opposite trends in work practices seem to have similarly deleterious health effects, *overemployment* and *underemployment* (Winefield, Montgomery *et al.*, 2002*)*. Overemployment has been linked to cardiovascular disease for some time (Breslow & Buell, 1960). The risk of heart attack for those working long hours (for example, 11 hours) is 2.5 times the risk of those working an 8-hour day (Sokejima & Kagamimori, 1998). The resulting increases in workload and in job insecurity have deleterious effects on both the remaining workers and the organisation. The stress of overwork can lead to psychological problems, including depression, burnout and breakdowns, to health problems, including heart attacks and hypertension, and to organisational problems, including workplace violence or accidents (Quick, Quick, Nelson & Hurrell, 1997). All of these problems can result in increased costs to the organisation that cancel out the short-term cost savings made by downsizing, resulting in no real improvement in long-term profitability (Cascio, 1995a).

The increased costs of occupational stress in the form of absenteeism, reduced productivity, compensation claims, health insurance and medical expenses has led to a growing interest by researchers into its causes, both in Australia and internationally (e.g. Cooper & Payne, 1988; Quick, Murphy & Hurrell, 1992; Cotton, 1995; Dollard & Winefield, 1996, 1998). Even jobs traditionally regarded as relatively stress-free, such as university teaching, are becoming increasingly stressful (Winefield, A., 2000; Winefield & Jarrett, 2001; Winefield, Gillespie, Stough, Dua & Hapuarachchi, 2002).

Quinlan (2002) describes the results of recent reviews on the health effects of precarious (casual, short-term, temporary, self-) employment in 11 countries, from 1986 to 2000 (Quinlan, Mayhew & Bohle, 2001), and also on the health effects of downsizing/restructuring and job insecurity published in the international literature between 1966 and 2001 (Bohle, Quinlan & Mayhew, 2001). Overwhelmingly the reviews found a measurable deterioration in health effects for precarious and survivor groups. The latter review found that those most affected among surviving workers were committed workers, older workers, and those subject to ongoing insecurity.

Workers are now being required to perform multiple tasks, learn new skills, and self-manage to meet competitive demands. According to Kendall *et al.*, (2000) this has lead to jobs that are more fluid (Cooper, Dewe & O'Driscoll, 2001), possibly exacerbating role ambiguity and role conflict, and leading in turn to work stress and illness (Dunnette, 1998).

For many workers the amount and scope of work has diminished with technological advances leading to *underemployment* (Cooper *et al.*, 2001) and this can also be risky. Research has found that those working less than 6 hours per day have 3 times the risk of heart attack than those working an 8-hour day (Sokejima & Kagamimori, 1998). Winefield, Montgomery *et al.* (2002), however, point out that those working lower hours may have been doing so because they were already suffering from the stress of too high a workload.

Organisations have downsized and restructured to improve flexibility and competitiveness or as a result of economic recession (Kawakami, 2000) leading to both mental and physical ill health (Chang, 2000). Flatter organisational structures are hazardous as workers find career options limited (Kasl, 1998). Belkic, Schnall, Landsbergis & Baker (2000) argue that modern work demands are squeezing out 'passive' and 'relaxed' jobs (for example, scientists increasingly compete for funding; general practitioners participate in settings of corporate managed care) which may lead to two classes of occupations: those with high control and low control, but *all* with high demands.

Emotional work

Emotional work refers to all the time and energy consuming activities that help others to regulate their emotional states (for example, peace-keeping and social skills training with children, negotiation of needs for dependent elderly relatives, building cohesion in family and workplace units etc). These activities are usually unpaid (and performed by women), although vital to the harmony and effective psychological functioning of many communities and their individual members (Strazdins, 2000).

Until the age of 60, women outnumber men as carers, reaching a peak in numbers about age 50 (Phillipson, 1982). Most of these, if no longer caring for children now grown up, care for spouses, elderly parents or handicapped relatives. Overall, women are more likely to be carers than men, but after age 60 caring for partners predominates, with slightly more men than women likely to be the 'principal resident carers' as wives become frail (McCallum & Geiselhart, 1996; Fallon, 1997).

The work of caring for disabled relatives can be isolating and burdensome. Greater recognition from professional carers, and more training and support resources, are some of the policy initiatives that might increase family caregivers' satisfaction from this work (Winefield, H., 2000).

Except in rare instances (such as the payment of a 'stipend' by a husband to a wife), work in the home is not regarded as paid work in the same way as is payment for domestic labour (for example, housekeeper, cleaning service). The latter is included in estimates of Gross National Product (GNP), whereas the former is not. Although much work in the home is tedious, repetitive and laborious (in spite of technological innovations), much familial work involves elements of benefit to others, interpersonal 'caring' and reciprocity that are not demanded to the same extent by any other workplace (Goodnow & Bowes, 1994).

Surveys in Australia (Bittman, 1991, 1994) indicate women spend more time on work in and about the home than men, in some studies more than four times as much as men. A common pattern often reported is the division of household work into 'outside' (car, garden, repairs) and 'inside' (everything else), with occasional sharing of shopping and child-care. The patterns of engagement by men and women in household work are, however, changing (Bittman, 1994). Women are cutting back on time spent in the kitchen and laundry, and are contributing more of their time to traditional male 'outside' duties. Men are spending less time in unpaid tasks than women still do, but are spending more time on childcare.

Research has shown that Australian couples who share housework and are prepared to change conventional work roles attribute their success to flexibility, appropriate styles of 'talk', and ability to negotiate and 'see another's point of view' (Goodnow & Bowes, 1994). Equity, sharing and turning a united face to the world were common values enunciated by the partners.

Correlates of poor mental health at work

Explorations of mental health issues at work are generally conducted under the rubric of work stress. A generic definition of *job stress* given by the US National Institute of Occupational Safety and Health (1999) is:

> ...harmful physical and emotional responses that occur when the requirements of the job do not match the capabilities, resources, or needs of the worker. Job stress can lead to poor health and even injury (p6).

Stressors may be physical or psychosocial in origin and both can affect physical and psychological health, and may interact with each other (Cox, Griffiths & Rial-Gonzalez, 2000). Physical stressors may include biological, biomechanical, chemical and radiological, or psychosocial hazards. Psychosocial hazards (stressors) are 'those aspects of work design and the organisation and management of work, and their social and environmental contexts, which have the potential for causing psychological, social or physical harm' (Cox & Griffiths, 1996, p87).

Exposure to stressors does not necessarily cause health problems in all people. In many cases while exposure to the stressors taxes the psychophysiological mechanisms involved, within normal homeostatic limits the stressor need not cause lasting damage (Cox *et al.*, 2000). While the experience may be accompanied by feelings of emotional discomfort, and may significantly affect wellbeing *at the time*, it does not necessarily lead to the development of a psychological or physiological disorder (Cox *et al.*, 2000). In some cases however, the stressor could influence pathogenesis: stress may affect health (Cox *et al.*, 2000). Further, the health state itself may act as a stressor, as it may sensitise people to other sources of stress by reducing their ability to cope (Cox *et al.*, 2000) and 'the common assumption of a relationship between the experience of stress and poor health appears justified' (Cox *et al.*, 2000, p76).

Strain refers to reactions to the condition of stress. These reactions may be transitory, but short-term strains are presumed to have longer-term outcomes (Sauter, Murphy & Hurrell, 1990). Occupational strain may include psychological effects (for example, cognitive effects, inability to concentrate, anxiety, depression), behavioural effects (for example, use of smoking, alcohol), and physiological effects (for example, increased blood pressure).

Work stress research in general attempts to draw links between taxing aspects of the work environment (stressors), perceptions and appraisals of these, and manifestations of strain including physiological, psychological, and behavioural changes that may result (Baker, 1985; Greenhaus & Parasuraman, 1987). Strain has consequences for both the work and non-work domains and can affect work performance, and result in absenteeism, industrial accidents and staff turnover all at considerable cost (Greenhaus & Parasuraman, 1987).

According to WHO (2001), mental health problems and stress-related disorders are the biggest overall cause of premature death in Europe. In Australia, the Australian Workplace and Industrial Relations Survey (1995), reported that 26% of people rate work stress as the second largest cause of work-related injury and illness behind physical strains and sprains, 43% (see extract from the 'Comparison of Workers' Compensation Arrangements in Australian Jurisdictions', July, 2000).

Cost of poor mental health at work

In Australia workers are generally entitled to workers' compensation for stress when the claimant's employment significantly contributed to stress, not including situations where reasonable disciplinary action or failure to obtain a promotion, transfer or other benefit in relation to employment occurred. In South Australia and most other states, the 'stress' condition is required to be 'outside the bounds of normal mental functioning' (Workcover, 1999, p14), or is a psychiatric condition listed in the

'Diagnostic and Statistical Manual of Mental Disorders', 4th edition, revised (American Psychiatric Association, 2000) or the 'International Classification of Diseases: Classification of Mental and Behavioural Disorders', 10th edition (WHO, 1993). Examples include post-traumatic stress disorder, stress adjustment disorder, clinical depression and anxiety.

The cost and prevalence of such claims vary from state to state. The following details are drawn from the 'Extract from the Comparison of Workers' Compensation Arrangements in Australian Jurisdictions', July, 2000, to give some insight into the prevalence, cost, and peculiarities of stress claims. In New South Wales in 1999/2000, there were 1,577 new claims comprising 17% of all occupational disease claims, each at an average cost of $20,617 per claim, with the total gross cost being $33 million. The largest proportion of claims (20%) was from Health and Education where large groups of professionals coalesce. In Victoria, 5% of claims were for stress in 1997/98 (1,587 new claims). Apart from circulatory disease and back injury claims, stress claims *were most costly* and represented the highest average payment per claim. The Victorian Workcover Authority declared stress as a *significant* cause of 86 deaths since 1985, *including* 15 suicides.

In South Australia, there were 162 claims in 1998/99 accounting for 2% of all injuries and 3.5% of all income maintenance costs. In Western Australia, 601 claims were lodged in 1997/98 for work stress, 2.2% of all claims with a claim cost of $23,399 twice that of other claims (an increase of 34% from 1996/97). In Queensland, an increase of 19% was found in 1999/2000 and an increase of 28% in 2000/2001. The average cost of the claim was $17,249 over *twice* that of the next most expensive. A striking statistic is that the average duration of time off for psychological/psychiatric claims was 96.1 days compared to 28.9 days for other claims.

In sum, most states report an increasing number of stress claims per annum, and although the percentage relative to all other claims is low, the cost per claim is generally much higher. It is difficult to derive a GDP figure for stress at work in Australia, as data sets between state jurisdictions are incomplete. However, excluding Victoria and Australian Capital Territory data, estimates are around $49 million in 1995/96 (National Occupation Health and Safety Commission, 1998) with an *additional* $38 million for Commonwealth workers in 1995/96 (Australian National Audit Office, 1997).

Too much work

Work stress theories attempt to describe, explain and predict when work stress will occur. A range of different theories has been proposed and each has a different emphasis which, as will be seen, leads to different implications for intervention. In summary, there is a plethora of theories used as guiding frames for the interpretation of work stress problems (see Cooper, 1998), and we have canvassed but a few here. As work stress has multiple origins, various theories and aspects of them have found empirical support in the literature. However, the dominant view based on empirical evidence is that work stress and its attendant mental health issues are firmly grounded in the way jobs are constructed, constituted and managed. In other words, they are socially determined.

Demand Control Support Model

This model of work stress emphasises social determinants of mental health at work. It argues that work stress primarily arises from the structural or organisational aspects of the work environment rather than from personal attributes or demographics of the situation (Karasek, 1979). According to Karasek, Baker, Marxer, Ahlbom & Theorell (1981):

> ...strain results from the joint effects of the demands of the work situation (stressors) and environmental moderators of stress, particularly the range of decision-making freedom (control) available to the worker facing those demands (p695).

Faced with high levels of demands and a lack of control over decision-making and skill utilisation, the associated arousal cannot be channelled into an effective coping response (for example, participation in social activities and informal rituals). Unresolved strain may in turn accumulate and, as it builds up, can result in anxiety, depression, psychosomatic complaints and cardiovascular disease. In this way mental and physical health outcomes are socially determined by the way in which jobs are constructed.

According to the model, workers such as those in machine paced jobs, assemblers, and service-based cooks and waiters, experience the highest levels of stress because they are in jobs high in demands and low in control. Executives and some professionals on the other hand are more commonly in jobs combining high levels of demands, but also high levels of autonomy. Therefore they do not experience high levels of stress despite popular suggestions (that is, executive stress). Presumably high status workers have the opportunity to regulate high levels of demands through frequent opportunities to use control, and mobilise resources (Karasek & Theorell, 2000). Social support at work is also a key buffer to work strain (Johnson & Hall, 1988). There is a considerable body of evidence on the beneficial effects of social support, in particular emotional support on aspects of mental health such as depression and anxiety, and physical health such as cardiovascular, endocrine and immune systems (Uchino, Cacioppo & Keicolt-Glaser, 1996). Jobs with high demands, low control and low support from supervisors or co-workers carry the highest risk for psychological or physical disorders (high strain-isolated jobs) with:

- increased risk of psychiatric disorder over time (Stansfeld, Fuhrer, Shipley, & Marmot, 1999)
- job dissatisfaction, burnout, depression and psychosomatic symptoms (Landsbergis, 1998)
- lower vitality and mental health, higher pain, and increased risk of both physical and emotional limitations (Amick, Kawachi, Coakley, Lerner, Levine, & Colditz, 1998).

Burnout Theory

'Burnout' is a term commonly used to describe intense emotional exhaustion and has been commonly associated with the taxing emotional demands associated with working with (troubled) people. Human service work is argued to impose special stressors on workers because of the client's emotional demands (Maslach, 1978, 1982). Some studies have found, however, that stressors such as clients' emotional demands, or problems associated with the professional helping role (such as failure to live up to one's own ideals), were less potent in predicting stress than those associated with non-helping professions (Shinn, Morch, Robinson & Neuner, 1993; Collings & Murray, 1996). Moreover, organisational variables were more strongly associated with job satisfaction and burnout than were client factors (Jayaratne, Himle & Chess, 1995; Barak, Nissly & Levin, 2001). The overwhelming empirical results indicating that organisational and job factors are the key influences on burnout are further supported in Australian research on (N=813) human service workers (Dollard *et al.*, 2001) and a longitudinal study of (N=123) rural social workers (Lonne, *in press*). The origin of burnout (occupational stress) is therefore 'fundamentally a systemic issue that involves serious conflicts and tensions, but which manifests itself in psychological and health strains for individual workers' (Lonne, *in press*, p301).

Effort-Reward Imbalance Model (ERI)

This model (Siegrist, 1996, 1998) derives from sociological and industrial medical frameworks, and emphasises the social framework of the job (for example, social status of job). Workers expend effort at work and expect rewards as part of a socially (negotiated) organised exchange process. In adult life the work role provides a crucial link between self-regulatory functions such as self-efficacy and self-esteem and a social structure within which to access opportunities for fulfilment. When a worker puts in an effort at work that does not seem to be adequately rewarded, strain results. Similarly when workers experience a threat to their job security (status) an imbalance results that can lead to strain. In addition to important socially structured aspects of the job, ERI further identifies the importance of intrinsic efforts – a personal characteristic of coping, a pattern of excessive striving in combination with a strong desire for being approved and esteemed. Like Type A behaviour, over-commitment may predispose a high need for control and immersion in the job, and probably a personal perception of low rewards. Effort-reward imbalance and over-commitment are found to be important in explaining adverse health effects such as gastrointestinal disorders, psychiatric disorders and poor subjective health (see Siegrist & Peter, 2000).

Person-Environment Fit Model

The Person-Environment (P-E) Fit Model (see French, Rogers & Cobb, 1974) emphasises the extent to which 1) individual skills and abilities match the demands of the job and 2) personal needs are supplied by the job environment. When misfit of either kind is present, strains such as job dissatisfaction, anxiety, depression and absenteeism can occur.

Cognitive Phenomenological Theory

Stress is defined in this approach as a relationship between the person and the environment that is appraised as taxing or exceeding resources, and endangers wellbeing (Lazarus & Folkman, 1984). Appraisal of stress is necessary. '[F]or threat to occur, an evaluation must be made of the situation to the effect that a harm is signified' (Lazarus, 1966, p44). If a situation is perceived as stressful and important then the worker mobilises different coping strategies either to modify the person-environment relationship (that is, problem focused coping) or to attempt to regulate resulting emotional distress (that is, emotion-focused coping). The situation is then reappraised and the process repeated. If the situation is resolved, coping ceases. If it is unresolved then psychological and physiological strain persist resulting in longer-term negative effects on health and wellbeing (Lazarus & Folkman, 1984). The theory has limitations in the work stress context as it cannot specify which aspects of the work environment would be stressful because, according to the theory, different individuals might see the environment in different ways (Baker, 1985).

Evaluation of work stress theories

Overall, empirical research has generally shown that job factors are more strongly related to job strain and burnout than are biographical or personal factors (Maslach & Schaufeli, 1993). Job related stress and adverse psychological states appear to be determined situationally rather than pathologically. A major criticism of the work environment approach is that it is simplistic and promulgates the notion of the individual as passive, ignoring the strong mediation effects of cognitive as well as situational (contextual) factors in the overall stress process (Cox *et al.*, 2000).

On the other hand when stress is understood in terms of perception and individual differences it is likely to be viewed as an individual problem and re-organisation of work processes may be avoided. These opposing views highlight the potential conflict between broader notions of health and safety in the workplace and the economic goals of business and industry in the investigation of work stress (Baker, 1985).

Not enough work

Unemployment has become a major social issue during the past 20 years. Even countries where unemployment remained low during the 1983 recession have experienced increased unemployment since 1990, although by the end of the decade official rates in many countries had declined. Globalisation has led to restructuring and downsizing in many industrialised societies and a shift, for many workers, from the prospect of secure, long-term employment, to unemployment or inadequate or insecure employment. There is growing evidence that the negative consequences of this shift are not merely economic, but also psychological. This section reviews the recent research literature examining the psychological effects of unemployment and inadequate employment on mature job losers and on school leavers. Finally, it speculates declining birthrates in many countries are a likely consequence of an increasing shift from secure to insecure employment and the possibility that in the future, society might need to encourage older retirees to re-enter the workforce so they do not become an excessive burden on younger workers.

Many economists view unemployment (or inadequate employment) as an economic not a psychological problem. The rejoinder to this view is that although the causes of unemployment may be economic, the psychological consequences go beyond the economic (that is, financial disadvantage). But this rejoinder needs to be supported by empirical evidence.

Winefield (1995) presented a comprehensive review of the literature on psychological costs of unemployment. Research literature has demonstrated there are substantial costs, both to the individual and family, which cannot be attributed solely to economic deprivation. Psychological researchers have had to address two issues in arriving at these conclusions. The first has been to demonstrate the psychological effects of unemployment cannot be attributed to economic/financial factors alone, and the second has been to establish the causal link underlying the observed correlation between employment status and psychological wellbeing.

Much published psychological research on unemployment has concentrated on the possible damage to mental health or psychological wellbeing caused by unemployment, with the 'selection vs exposure' issue a major pre-occupation (e.g. Hammarström & Janlert, 1997). That is, given the common observation that employed individuals are less depressed and show higher self-esteem than their unemployed counterparts, can we attribute the difference to employment status ('exposure'), or does a pre-existing difference in psychological wellbeing influence whether one will obtain and/or retain employment ('selection')? Sophisticated longitudinal studies have been carried out designed to tease out selection and exposure effects (e.g. Winefield *et al.*, 1993). The evidence seems to suggest when jobs are plentiful, unemployed individuals tend to be generally unemployable or else 'workshy' (Tiffany, Cowan & Tiffany, 1970) in support of the selection hypothesis, whereas when jobs are scarce there is clear evidence supporting the exposure hypothesis (Winefield, 1995, 1997). Presumably the same considerations would apply to the effects of underemployment.

Psychological theories of unemployment

Stages Theory

Eisenberg and Lazarsfeld (1938) published a review article summarising much of the pre-World War 2 literature on the psychological effects of unemployment. They concluded the psychological response to unemployment could be described in terms of the following discrete stages:

> First there is shock, which is followed by an active hunt for a job, during which the individual is still optimistic and unresigned; he (sic) still maintains an unbroken attitude. Second, when all efforts fail, the individual becomes pessimistic, anxious, and suffers active distress; this is the most crucial stage of all. And third, the individual becomes fatalistic and adapts himself (sic) to his new state but with a narrower scope. He (sic) now has a broken attitude (p378).

Although subsequent commentators have agreed about the stages, Fryer (1985) has published a highly critical review in which he argues the empirical evidence does not support the view that job losers progress through them in a unidirectional way, as assumed by the theory.

Frustration Theory

Dollard, Doob, Miller *et al.* (1939) proposed the frustration-aggression hypothesis that assumes a) frustration always leads to aggression, and b) aggression always presupposes the existence of frustration. The theory was originally developed to explain reactions to economic deprivation during the Great Depression, and has recently been applied to explain reactions to job loss (e.g. Catalano, Dooley, Novaco *et al.*, 1993).

Life-span Developmental Theory

Erikson (1959) proposed 8 stages, each with associated conflicts that need resolution for healthy psychosocial development:

1. Infancy – trust vs mistrust.
2. Early Childhood – autonomy vs shame.
6. Play Age – initiative vs guilt.
3. School Age – industry vs inferiority.
4. Adolescence – identity vs identity diffusion. Identity refers to a) sexual identity, and b) occupational identity.
5. Young Adulthood – intimacy vs isolation.
6. Adulthood – generativity vs stagnation.
7. Old Age – integrity vs despair.

In relation to adolescence, some researchers have reported evidence suggesting that youth unemployment retards healthy psychosocial development, as predicted by the theory because it prevents the acquisition of occupational identity (e.g. Gurney, 1980).

Deprivation Theory

Based on Freud's view that work represents our strongest tie to reality, Jahoda (1981) has proposed a theory that distinguishes between the manifest benefits of employment (e.g. earning a living) and its assumed latent benefits that serve to maintain links with reality. She identifies five latent benefits:

1. Time structure.
2. Social contact.
3. External goals.
4. Status and identity.
5. Enforced activity.

Jahoda also believes that even bad jobs are preferable to unemployment, 'even unpleasant ties to reality are preferable to their absence...Leisure activities...are fine in themselves as a complement to employment, but they are not functional alternatives to work' (1981, p189).

This belief has not been supported by the research evidence, with studies by O'Brien & Feather (1990), Winefield *et al.* (1993) and Dooley & Prause (2000) showing that inadequate employment can be just as psychologically damaging as unemployment. Some researchers have attempted to measure access to the five latent benefits of employment and have claimed that in unemployed people, access (through leisure activities) is correlated with psychological wellbeing (Evans & Haworth, 1991).

Agency Restriction Theory

Fryer has proposed what he calls an Agency Restriction Theory as an alternative to Deprivation Theory (Fryer & Payne, 1984; Fryer, 1986). He criticises Jahoda's Deprivation Theory on the ground that the five supposed latent benefits of employment are all too often costs rather than benefits. He writes of 'Arbitrary time structure without regard for human needs; autocratic supervision; activity for unclear or devalued purposes; a resented identity; [and] the vacuous nature of imposed activities' (Fryer 1986, pp12-13).

The theory assumes that people are agents who strive to assert themselves, initiate and influence events and are intrinsically motivated.

In short, agency theory assumes that people are fundamentally proactive and independent, whereas deprivation theory, by contrast, assumes them to be fundamentally reactive and dependent.

According to Agency Restriction Theory, the negative consequences of unemployment arise because they inhibit the exercise of personal agency. The restrictions imposed by economic deprivation make it difficult or impossible for people to plan and organise personally satisfying life styles. Most people work for the manifest benefit of employment without regard to its so-called latent benefits. The regular income enables them to plan and organise personally satisfying leisure activities and to save for, and plan for a satisfying retirement. Fryer (1986) argues that the role of poverty has been under-emphasised in much of the contemporary research on unemployment compared with the research carried out in the 1930s.

The Vitamin Model

Warr's (1987) Vitamin Model assumes that nine features of the environment (opportunity for control, opportunity for skill use, externally generated goals, variety, environmental clarity, availability of money, physical security, opportunity for interpersonal contact, and valued social position) affect mental health in an analogous manner to the way vitamins affect physical health.

Some of the environmental features are assumed to resemble vitamins A and D in that very high levels not merely cease to be beneficial, but are actually harmful (AD is a convenient abbreviation for 'additional decrement'). Others are assumed to resemble vitamins C and E in that very high levels, while ceasing to be beneficial, are not actually harmful (CE is a convenient abbreviation for 'constant effect'). Warr suggests that three of the environmental features – availability of money, physical security and valued social position – may reasonably be regarded as falling within the CE category, whereas the remaining six are regarded as falling within the AD category.

Like Agency Restriction Theory, but unlike Deprivation Theory, the Vitamin Model draws no sharp distinction between employment and unemployment but rather sees the overall quality of the environment (assessed in terms of nine characteristics) as important for mental health. It goes beyond Agency Restriction Theory in specifying which features of the environment are important. On the other hand, most of the features (e.g. opportunity for control, opportunity for skill use, availability of money, physical security, opportunity for interpersonal contact, and valued social position) would obviously facilitate the exercise of agency and are thus implied by Agency Restriction Theory.

Although Warr's Vitamin Model differs from Jahoda's Deprivation Theory in that it assumes no qualitative distinction between employment and unemployment, Warr nevertheless acknowledges the importance of Jahoda's theorising and its influence on his own thinking. For example, Jahoda's second and fourth latent functions (contact with people outside the nuclear family, and personal status and identity) appear as environmental features 8 and 9 in the Vitamin Model (opportunity for interpersonal contact and valued social position) and her other 3 latent functions are incorporated within 'externally generated goals'.

Relative Deprivation Theory

Relative Deprivation Theory (Crosby, 1976; Walker & Mann, 1987) has recently been applied by Feldman, Leana and Turnley (1997) to explain reactions to unemployment and underemployment. In relation to employment status, relative deprivation may be defined as a perceived discrepancy between an individual's actual status and the status that he/she expects and feels entitled to. It involves two cognitive components: a perception of violated expectations and a judgment as to the legitimacy of the violation (Walker, personal communication), both of which can be operationalised and measured.

Coping with organisational change

The increasing globalisation of the Australian economy means that we are more economically exposed to events taking place in other countries. Globalisation has meant increased competition and opportunity for Australian business. Successful businesses are the ones that can best adapt in response to competition. Being able to adapt means relying on a flexible workforce that manages change successfully. Yet people are generally more comfortable continuing to work in accustomed ways. People have an understandable need for job security and, because of the fear of job loss, tend to resist rationalisation, new technologies, and new procedures. Organisations may resist change because of group inertia and the threat that change poses to established modes of decision-making. Negative reactions to change, especially imposed change, include distress in the form of anxiety and depression, decreased job satisfaction, decreased organisational commitment, resistance to change, deterioration in organisational morale, reduced job performance, increased voluntary resignations, and absenteeism (Collins, 1998).

There is now abundant evidence identifying the key role played by open communication in successfully managing organisational and workplace changes. Traditional management preferences for hierarchical and secretive decision-making create an environment for gossip and rumour-mongering, which have demoralising effects on workers. Informing workers openly and fully, even of problems facing an organisation, facilitates their participation in solving those problems and coming to terms with necessary changes (Gowing, Kraft & Quick, 1997). There is little evidence, however, of an increase in open communication surrounding workplace change. There is a continued use of secretive and autocratic decision-making in the recent highly public workplace changes (the 1998 Melbourne waterfront dispute for example). The increasingly global economy may increase this trend as decisions about workplace closures are made outside of the plant or section that is to be closed.

The continually changing face and nature of work today requires adaptive coping strategies that allow for easier and expected transitions from one type of work to another, in a context of life-long learning and change. This may entail less dependence on defining who one is exclusively in terms of what one 'does for a living'.

The traditional practice of obtaining one job for life is disappearing and it is increasingly the pattern of employment for one person to have a sequence of jobs, which may differ in skill requirements, with possible

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periods of unemployment in between. There is, therefore, a need for young people to learn work-related skills, but these are increasingly likely to be generic skills rather than preparation for a particular job.

These skills would require young people to view change as an inevitable part of life. This would entail seeing job security as a readiness and an ability to adapt rather than expecting to learn a certain set of skills that will guarantee life-long employment. However, the development of such an optimistic attitude requires some opportunity to experience a sense of mastery. Our young people have a basic right to reasonable levels of respect, support and security within which a realistic 'can-do' attitude can be fostered, particularly during transitional periods such as leaving school.

The nature of employment in Australia in the future will require a readiness on the part of employees to manage change both while in the workforce and when moving in and out of employment. Research has revealed several factors influencing people's ability to cope with change. Different styles of coping are required as a function of situation, time and person - that is, what works in one situation may not work in another. A distinction is often made between problem-focused coping and emotion-focused coping (Kinicki, McKee & Wade, 1996). Persons employing problem-focused coping strategies are likely to deal with the stressful situation by taking action that directly helps to find a solution to the problem being faced. For a person who is unemployed, this might mean taking steps to re-skill or to apply for new positions. A person employing emotion-focused coping is likely to deal with personal feelings and reactions to the problem and may avoid solving it. The second strategy may be less adaptive in an unstable employment market and is more likely to lead to related health problems. However, emotion-focused coping may be more effective than problem-focused coping when a situation cannot be changed, such as a bereavement. For some job-seekers, this may be a realistic assessment of the employment market.

Research has suggested that those who are more likely to use problem-focused coping are characterised by a greater sense of optimism and sense of mastery (Armstrong-Stassen, 1994). Optimism can be defined as a generalised expectancy that good things will happen. Sense of mastery can be described as having a belief that one's life chances are under one's own control in contrast to being determined by fate. A person with a strong sense of mastery and high level of optimism is likely to approach change in a positive way. In addition, employees with these characteristics are likely to exhibit a high level of work commitment, even in the face of uncertainty.

Is it possible to increase the level of optimism and sense of mastery that people possess? An individual's attitude to life and work, in particular, is influenced by personal upbringing, dispositional traits, life experiences and cultural factors. Research has shown that children whose disposition tends towards the pessimistic can be guided into thinking more optimistically (Seligman, 1997).

Cross-cultural aspects of work

Many of our traditional ideas about 'work' and 'non-work' are culture-bound. Westerners live in largely industrialised societies and cultures with clearly demarcated domains of 'work' or 'gainful employment' that is highly valued, which can dramatically impact on individual identity and status, which largely determines residential location and often education, and which takes up a large part of people's lives. The other side of this western institutionalisation of work and the work ethic is that not to 'have work' is to see oneself as a failure: to have an indeterminate identity and status; to be perceived as 'carried' by the work of others; to be dependent; and to have an uncertain future. While it can and has been argued that 'work' simply differs from culture to culture, with different types of economies, the reality in terms of cultural assumptions and meaning systems is that the very construct of 'work' differs profoundly from culture to culture.

Even in western European cultures, which are superficially homogenous, work values differ markedly (e.g. Hofstede, 1980). The domain of work and cultural values is of particular interest in Australia, given the cultural heterogeneity of the population (including Indigenous people and immigrants), the high work aspirations of migrants, and a popular conception of Australia overseas that, in Australia, people 'work to live' as distinct from America and parts of Europe, where people basically 'live to work'. There are also differences across generations, with Australia's young people occupying a different cultural space from their parents, and often having different values with respect to self, life and nature and importance of work (Frydenberg, 1994)

We need to keep in mind that western cultural value stances and assumptions are in part responsible for a number of unfavourable stereotypes with respect to differing rates of paid employment in other cultural contexts. For example, high rates of unemployment in Aboriginal communities are regularly cited as negative social indicators, yet these reflect both pervasive structural inequalities as well as a very different cultural value system. While there has been some research on 'work values' among Indigenous Australians, it has been almost always in the context of non-Aboriginal and largely western cultural assumptions and in the context of community development initiatives aimed at providing an 'economic base' and 'self-sufficiency', based on values alien to Indigenous culture. Similarly, perspectives on health inequalities for women and ethnic minorities closely reflect income inequalities:

> Indeed, there seems to be a 'culture of inequality', which is characterised by the exercise of patriarchal power by men over women, as well as high levels of collective prejudice against racial minorities. The health status of subordinated groups in society thus seems to be inextricably linked to the general quality of the social environment, and hence to economic inequality (Kawachi, Kennedy & Wilkinson, 1999, p447).

In western cultures we have tended to isolate and reify 'work' as a self-defining life context, as the subject of intellectual and popular discussions, as part and product of a motivational and economic engine that drives society and progress. We work 'at work' and work 'at home', it's what we 'do' for a 'living'. While many are questioning increasing incompatibilities between having a life and having a career, what drives and defines the cultural ideal in Australia is a self-defining, self-satisfying 'job'. These are relatively strange and alien notions in many non-western cultures, where 'work' is a more integral part of living and being and is not a reflective object of consideration, study, and cultural elaboration.

A cross-cultural perspective allows us some intellectual purchase on where and how and what we identify as 'work' impacts on people's lives. This is particularly valuable at a time when cultures and, indeed, the nature of self and society (e.g. Sampson, 1989; Gergen, 1991) are changing rapidly. It is true at both ends of the generational continuum, with many older persons bridging a further generational divide and living far past the traditional age of 'retirement'. Such a perspective cautions us against seeing alternative life styles as necessarily problematic, while at the same time understanding the self-defining, esteem-providing, and dignity-enhancing dividends that culturally valued 'work' can provide in particular cultural contexts. We clearly need some different ways of understanding and thinking about 'work'. We are entering a millennium in which 'work' may become a less central part of who and what people are. We need to accommodate better cultural understandings of personhood, and connections, and of meaning and self-fulfilment. The experience of other cultures allows us to broaden, redefine and reconstrue (e.g. Davidson & Reser, 1996) the nature of 'work' and its relation to life satisfaction and quality of life.

The balance: healthy productive work

Although the negative aspects of jobs seem highlighted, there are positive combinations of job elements with potential to lead to satisfaction, efficacy, and high performance. A study of Australian correctional officers (*N*=419) by Dollard and Winefield (1998) showed that the level of active coping (seeking feedback from supervisors, seeking support) was significantly higher in jobs combining high demands and high control than in passive jobs (not enough demands) – consistent with the idea that workers experiencing passive jobs, with little opportunity for control, will show reduced motivation to tackle new problems. Another Australian study of human service workers (*N*=812) found those involved in active jobs also had higher levels of efficacy, namely satisfaction, personal accomplishment (Dollard *et al.*, 2001), and this in turn was negatively associated with strain (psychological distress, emotional exhaustion, physical health symptoms). A study of Australian clergy (*N*=359) also found a negative relationship between strain on the one hand, and efficacy on the other (Cotton, Dollard, de Jonge & Whetham, *in press*). Taken together, these studies provide some support for the dynamic associations between job strain and feelings of mastery (Karasek & Theorell, 1990). The higher the levels of efficacy experienced by workers the lower their levels of experienced psychological distress and physical ill health. This may be due to emotional and physiological toughening that occurs when workers have opportunity for both challenge and recovery in active jobs (see Dienstbier, 1989). When faced with new challenges, active workers will have a positive perceptual set that will enable them to meet new challenges, but without the negative consequences of accumulated strain.

Another study found increased worker motivation in 381 insurance company workers in active jobs (Demerouti, Bakker, de Jonge, Janssen & Schaufeli, 2001). However the researchers also found greater health impairment, leading to the conclusion that the levels of demands were in fact too high, that they could not be reduced by increasing control, and that neither too few or too many demands are good for employees (see Warr's Vitamin Model, 1987).

Recent meta-analytic studies from the United States suggest that the relationship between job satisfaction and job performance is much higher than had previously been assumed (Judge, Thoreson, Bono & Patton; 2001; Harter, Schmidt & Hays, 2002). Moreover, Koys (2001), using longitudinal unit-level data, has shown that human resource outcomes such as employee satisfaction, organisational citizenship behaviour and turnover, affect organisational outcomes such as productivity and customer satisfaction, rather than *vice versa*.

The importance of social support at work from colleagues and supervisors is underscored as it is consistently shown to be linked to better mental health outcomes for those who experience it. Particularly important appears to be the reaction of organisations, especially supervisors, when employees become either mentally or physically taxed, and also in return to work outcomes (for example, a phone call from the supervisor) should the employee need to be absent from the work environment (Linton, 1991; Dollard *et al.*, 2001). Workers also need protection from violence at work including bullying (in many cases perpetrated by supervisors), harassment and other intimidating behaviours, and the responsibility for preventing these behaviours rests mainly with supervisors. The policy section below outlines further ideas for the ideal work environment.

Research program for environmental and health action

An overall program for research and environmental and health action recently outlined by Levi (2002, px) should aim at being:

- Systems oriented, addressing health-related interactions in the person-environment ecosystem (e.g. family, school, work, hospital, and older people's home)
- Interdisciplinary, covering and integrating medical, physiological, emotional, behavioural, social, and economic aspects
- Oriented to problem solving, including epidemiological identification of health problems and their environmental and lifestyle correlates, followed by longitudinal interdisciplinary field studies of exposures, reactions, and health outcomes, and then by subsequent experimental evaluation under real-life conditions of presumably health-promoting and disease-preventing interventions
- Health oriented (not merely disease oriented), trying to identify what constitutes and promotes good health and counteracts ill health
- Intersectoral, promoting and evaluating environmental and health actions administered in other sectors (e.g. employment, housing, nutrition, traffic, and education)
- Participatory, interacting closely with potential caregivers, receivers, planners, and policymakers
- International, facilitating transcultural, collaborative, and complementary projects with centres in other countries.

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Levi (2002) further emphasises the importance of evaluating such interventions, to ensure harmful interventions are prevented, to safeguard human rights, to estimate costs-benefit of public expenditure, and advance knowledge of the future. Within this larger framework the following ideas for policies to improve mental health and wellbeing at work are offered.

Policies to improve mental health and wellbeing at work

A number of key policy implications from the evidence base, along with a philosophical framework as well as processes to deal with new stressors as they emerge were advanced as part of the National Occupational Health and Safety Symposium on the Occupational Health and Safety Implications of Stress, Melbourne 2001 (Dollard, 2001). The participation of a range of stakeholders in dialogue and research activities seems critical in the development of policy that is responsive to new insights from the field. A notable feature of the literature in the area is a dearth of large Australian national studies or indeed systematic organisation of the Australian evidence. This raises possibilities both at the national and organisational level. The following excerpt is from the NOHSC Symposium (Dollard, 2001, pp3-57):

National level

Policies that could be pursued at the national level include:

- providing further organisational support and funds to enable greater dialogue between all stakeholders, and to enable meaningful national engagement and participation in international discussion about work stress and its solutions
- convening further national conferences and workshops on work stress in which government, social partners, workers and researchers can participate
- undertaking research comparing Australian regulations, policies and practices with those in other countries (Kompier, De Gier, Smulders & Draaisma, 1994)
- promoting whole organisational approaches, healthy organisations, sustainable organisations and ethical action
- developing a national network of work stress researchers
- establishing a national monitoring system for identifying risk factors and risk groups in the working populations (Kompier *et al.*, 1994)
- making a systematic attempt to benchmark organisational performance on work stress management, so that intervention efforts can be more economically focused, e.g. to sponsor research of national risk factors and risk groups (Kompier *et al.*, 1994)

- making work stress research a priority for National Health and Medical Research Council
- supporting research that promotes positive or productive aspects of work such as morale (e.g. Hart & Cotton, 2002) and engagement (Maslach, 1998), and explores emerging issues e.g. emotional and cognitive demands (Houkes, Janssen, de Jonge & Nijhuis, 2001) and workplace violence, its causes and consequences
- developing more comprehensive national databases, e.g. NOHSC's database of workers' compensation statistics includes figures for work stress, but there is no breakdown of the data to reflect public vs private sector experience, and some jurisdictions' data are omitted
- conducting more research on the effect of new legislation on rates of acceptance or rejection of stress claims
- systematically identifying gaps between research evidence and policy
- providing more education and training on work stress and interventions for all stakeholders to enable fuller participation in participatory processes for prevention.

To date, most Australian case studies have essentially focused on individual approaches to intervention (Williamson, 1994) in comparison to European efforts. In contrast to research about what *causes* stress and burnout, very little gold standard research, with case controls and randomised approaches, has been conducted on *interventions that reduce work stress* or burnout. It is therefore recommended:

- Australian organisations be encouraged to use best practice principles in implementing interventions. At the same time there is an urgent need to conduct an evidence-based meta-analysis of Australian work stress prevention and interventions
- government, social partners, and researchers participate in television programs and videos on identification and prevention of stress at work
- development of a clearing house for all relevant information and other educational materials to be placed on WWW.

Organisational level

At the organisational level other measures are relevant, for example:

- focusing on primary prevention of work-related stress and ill health rather than on treatment
- promoting 'internal control' approaches to healthier workplaces (see below best–practice)
- ensuring proper training and career development for better person-environment fit

- ensuring optimum conditions for the introduction and uptake of new technologies, and integrating such introductions with stress prevention and health promotion
- promoting workers' motivations and adaptability through increased involvement in planning and implementation of change
- promoting equal opportunities and fair treatment of men and women, including selection and re-entry of women into the workforce and combining family and work responsibilities, to ensure the 'high level of human health protection' called for in the Treaty of Amsterdam (European Communities, 1997, p39)
- amending the education and training curriculum of various professionals to promote both the modernisation of organisational work and the prevention of work–related stress in an integrated manner (e.g. in business schools, schools of technology, medicine, behavioural and social sciences) (European Commission, 2000)
- improving work design, organisation and management (e.g. 360 degree evaluation of supervisors'/managers' styles) specifically to improve communications and staff involvement, and to enhance team working and control over work; develop a culture in which staff are valued; structure situations to promote formal and informal social support within the workplace; evaluate work demands and staffing; reduce violent exposures; define roles more clearly; avoid ambiguity in job security and career development; design work schedules to be more compatible for non-work responsibilities; and design forward, stable rotating shifts.
- using local information to inform the exploration of stress. In a workplace context it is never sufficient to limit the exploration to general global variables. There is also a need for 'local' and more focused information specific to the organisation
- providing secondary and tertiary support as necessary.

Guidelines for best practice in organisational implementation suggest they:

- need to be stepwise and systematic
- require an adequate diagnosis or risk analysis
- combine both work-directed and person-directed measures
- use a participatory approach (worker involvement) (Scheflen, Lawler & Hackman, 1971)
- have top management support (Kompier *et al.,* 1994)
- are evaluated for costs and benefits of the intervention and in terms of health and productivity outcomes (European Commission, 2000).

These recommendations are relevant and applicable in the Australian work environment today.

Conclusions

Recent modern work environments are increasingly characterised by 'too much work', 'not enough work' and 'no work' due to economic rationalism and local imperatives. Each of these unfavourable work states, emerging themselves from the way jobs are constituted, constructed and managed, has been associated with economic and social costs (for example, family issues), and increased risk for stress-related disorders and mental health problems. Further, the latter are significant contributors to the burden of disease, and are putatively linked to loss of quality of life and premature death (Wilkinson & Marmot, 1998; WHO, 2001). Income inequality arising from such disparate work states has negative health consequences for all members of society as social cohesion, which characterises healthy egalitarian societies, progressively breaks down (Wilkinson, 1996). Income and work inequalities (for example, emotional, care and house work) appear mirrored in health inequalities particularly apparent in women and ethnic/cultural minorities, clearly implicating a 'culture of inequality' characterised by 'patriarchal power by men over women as well as high levels of collective prejudice against racial minorities' (Kawachi *et al.*, 1999, p447) in the workplace.

In addition to workplace redesign and a redistribution of working hours among a greater number of employees without discrimination, building capacity within workers to cope is also an important ideal given the rate of change to the nature of work. Aspects of the ideal work environment have been explored in the chapter along with an agenda for research and evaluation, and policies for implementation at the national and organisational level.

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Dear Director (Dean, Manager or Principal)

Re: Employment Opportunities

Might you have a vacancy
for a reflective practitioner?
I'm learning to navigate Schon's swamp,
to recognise corporate crocodiles
& avoid administrative quicksand.
I'm becoming a critical thinker,
awakened to the discourses of power & privilege.
I've mastered my TLAs* CBT, ITB, RPL & the rest.
I'm right into Managing Change. I'll be clever & creative if I can,
willing to give re-training & multi-skilling a go.

It seems there are two categories under which I might apply,
Casual & Contract.
I have only two questions.

If you said I could be a Casual Employee
& I came in casual,
wearing shorts, thongs & T-shirt,
stashed my Esky under the desk,
put my feet up & said,
'OK dudes – what's on today?'
You'd say I wasn't professional
& show me how casual
is easily made into casualty.
Yet when I rush between jobs
hot & flustered in city traffic jams:
when my mind is fractured
into half a dozen different desks,
in different places, with different faces,
& what I want is always at the last one:
when I'm forced to make a hostage
of my professionalism
& cram it into a cardboard box
in the boot of my car:
when my spouse spits the dummy

at the endless unpaid hours
of preparation & development
& I am torn - because I respect my students
& I want to do it for them:
when I experience all of this,
it doesn't seem very casual to me.

So I ask, for whom is casual employment casual?

But perhaps you say I can go on Contract.
If so I can offer you professional
commitment & competence integrity & loyalty dedication to the work.

Yet it seems your contract
leaves little room for strategic planning,
with staff security shrunk to single semesters.
Curriculum Development is reduced to
punching out packages for 'flexible delivery'
by the Unknown Trainers who win the tender
& Professional Development
doesn't rate a mention in your contract,
though I'm sure you'll support me
with smiles & words of encouragement.
I notice your contract falls just short
of my vacation,
but worse, far worse,
it falls well short of my vocation.
I'm ready to work;
prepared to be challenged & stretched -
expanded to meet new horizons
& to continue developing.

And so my second question is,
why would you want to contract
my professionalism & my profession?

© P.J. Waterhouse
February 1994

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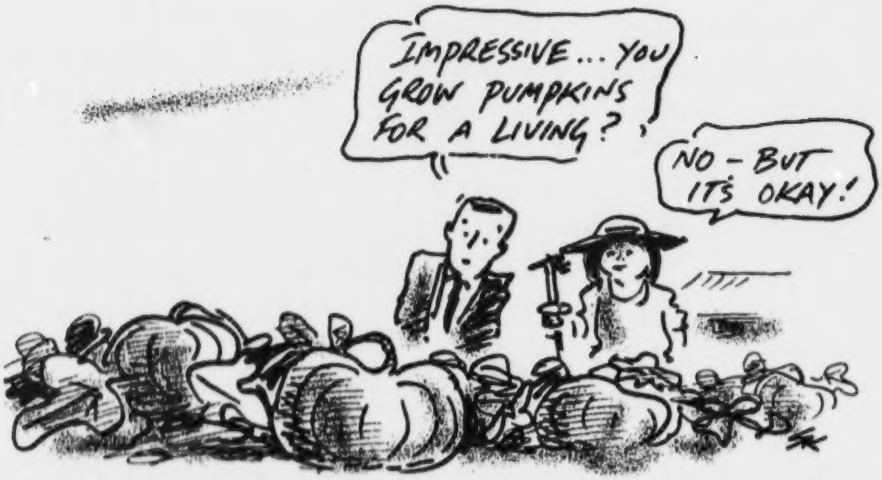
*TLAs - Three Letter Acronyms


IMPRESSIVE... YOU GROW PUMPKINS FOR A LIVING?
NO - BUT IT'S OKAY!

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Section II
Work and identity

In this book we have used the social/structural determinants of health such as age, gender, race, ethnicity and place as our initial framework for understanding identity. We think the first paper in this section by Suzette Dyer and Maria Humphries on *Normalising workplace change through contemporary career discourse* sets the scene for understanding the links between social stratification, life chances, personal identity and mental wellbeing. Drawing on both Foucault and Rose, Dyer and Humphries outline the way in which 'career discourses' and 'self-help' career guidance books provide advice that requires a constant and vigilant attention to the self, made and re-made in the image of the marketable employee.

The underlying critique of Dyer and Humphries' account of this discourse is its claim that you can plan a career in a volatile and precarious world of work, independently of any other social obligations or factors. The flexible worker emerging from the career discourse is neither gendered nor aged, but a neutered chameleon reflecting the needs of capital. In the modern state even the unemployed citizen eking out an existence on a highly regulated, but meagre welfare payment is sufficiently disciplined to *tighten his or her belt,* and recognise the problem can be overcome through remediating the self.

This is the ultimate technique in labour flexibility. Failure to secure a job is directly attributable to our inability to become a flexible self. It is not simply that flexible specialisation has resulted in downsizing, redundancies and work intensification. It has also produced the transformation of the soul.

Rosemary Hoban explores the inexorable link for many Indigenous people between their paid work and their Aboriginal selves. This is not simply a matter of working in Aboriginal welfare – it is also about the cultural blurring between the self as worker and provider, the reciprocal demands of one's community and the impact of Aboriginal dispossession and discrimination. Indigenous workers spend long hours at work, not just because of the enormous needs of their clients, but also because their work is their community. The irony of the vignettes in this chapter will not be lost on those workers who now find that their own work time bleeds over into private and family time. The consequences for burnout and workplace stress are obvious when even leisure time is contaminated with caring or meeting the expectations of others. The question of workplace discrimination is not far from the surface in the account of the Koori workers at the Rumbalara community.

Discrimination is also the subject pursued by Thea O'Connor and Bernadette Fallon in their separate accounts of working women's health and strategies for active employment for older workers. Thea O'Connor illustrates the complexities of what women want and how a mentally healthy workplace might accommodate the differing needs of women according to differences in life stage. It appears axiomatic that part-time work is important as an option, but so too is information and choice about their health and wellbeing. Fallon's account of the projects funded through the *Working for Ages* strategy indicate decreases in staff turnover and lower recruitment costs as positive outcomes of employing older workers. She notes that the issue is not just the employment of older workers now defined as anyone over 45, but the employment of a balanced number of staff across the age span. Mentally healthy workplaces are those with a balance of staff across the age spectrum.

However, employing staff across the life-span or providing flexible working time arrangements is not sufficient for ensuring mentally healthy workplaces. Work must also be satisfying and meaningful. This is the approach taken by Stephen Pavis, Stephen Platt and Gill Hubbard in their account of young people and work in rural Scotland. The focus of their paper are the concepts of social exclusion and social connectedness. Readers will find the discussion on the three political discourses used to explain social exclusion insightful for the way in which unemployment can be examined, most notably in asking the question, *Is any work more health promoting than no work*? The authors note that in Britain and to some extent more broadly across Europe, debate continues on the role of paid work in enhancing social cohesion.

The Pavis *et al.* study examines these contemporary debates on social exclusion through a case study of two rural towns in Scotland where varying opportunities for meaningful employment were available. Their results show that if employment is the defining element of social inclusion, then most young employed people in these two towns pass the test. However, they found that young people in low paying jobs, such as food processing and childcare, were clear these occupations did not provide opportunity for advancement or sufficient income to establish a home and family independently from their own parents, nor did they find the jobs satisfying. For Pavis, Platt and Hubbard, mental health promotion is not just a job, but real opportunities to engage in civil and economic life. Such opportunities require mentally healthy social policy not just in the workplace, but also in education.

Troy Speirs and Martyn Wilson bring together age, gender, work and identity in their discussion of the impact of retirement on older men. Their paper challenges men who leave retirement planning to chance, given that for many, personal identity is solely caught up in the status and quality of work. In such cases, the transition to retirement will be stressful. In outlining their argument, Speirs and Wilson focus on the intertwining of masculinity and work, challenging older men to rethink what it means to be male as an essential part of pre-retirement planning. More poignant is the plight of those forced out of the workplace in order to care for family members with a disability. The case example offered in the last chapter of the section, written by Alison Rosser, illustrates the social and political changes needed for this group of workers, or ex-workers to enjoy the opportunities of mentally healthy work environments. Rosser's paper reminds us that work is not the totality of social life. While providing for our material wants and those of family members, it should be remembered that paid work ought to integrate with other social responsibilities. Caring for disabled or sick family members is also a core activity in family life. The two activities should not be mutually exclusive, but ideally complement each other.

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2 Normalising workplace change through contemporary career discourse

Suzette Dyer and Maria Humphries

Embedded in the discourses of globalisation and flexibility is the argument that new political and economic relationships need transforming to generate flow-on benefits to wider society. Yet, resulting changes to employment and welfare provision in the last two decades have led to disparate outcomes globally. In this context, contemporary career discourse invites us to take responsibility for personal wellbeing and offers practical steps to achieve this. In light of the wider context, such discourse may be viewed as techniques to discipline wider society to accept uncritically political and economic changes as natural and inevitable.

Throughout the 1980s and 1990s, constant organisational downsizing, geographic relocation of firms, and the creation of flatter organisational structures have impacted upon employment. Early advocates of organisational structural reform argued a series of crises throughout the 1970s led to market instability during the 1980s (Bertram, 1993). By the 1990s it was argued that continued structural reform was needed to remain competitive in an increasingly global marketplace (Ehrensal, 1995). Throughout this time employers have sought various forms of labour flexibility as a necessary avenue to alleviate the economic 'realities' of the 1980s and 1990s (Dyer, 1998). Proponents promised labour flexibility would bring benefits to workers as well as to wider society through improved profits, and economic and job growth. Part of this seduction included notions of 'tightening belts' and 'shared hurts' in the short-term, to be replaced by ever-increasing growth and prosperity for all in the long term (Kelsey, 1995).

Less optimistic accounts suggest globalisation and flexibility have resulted in downward pressure on incomes, growing gaps between rich and poor within and between nations, less secure employment, poverty wages, and contradictory trends of overemployment, underemployment and unemployment (Pollert, 1991; Kelsey, 1995; McBride, 1999). Dent (1995) suggests unemployment may be a time fruitfully employed renewing skills to become more marketable in the ever-changing work environment, and provides time to spend with family, friends and developing community interests. In contrast, studies in various western economics have found that as unemployment rises there have been increased incidences of social withdrawal, anxiety, stress, physical and mental illness, alcoholism, drug abuse, family violence, child neglect, poverty entrapment, 'hate group' participation, suicide and crime (Ehrensal, 1995; Uchitelle & Kleinfeld, 1996; McBride, 1999).

Contemporary literature on career planning

In harmony with the changes to work characterised by constant downsizing, flattened structures, relocation and job insecurity is a growing body of contemporary career literature advising that traditional notions of upwardly mobile careers are no longer appropriate (Kanter-Moss, 1989; Greenhaus & Callanan, 1994; Hall & Associates, 1996). Contemporary career theorists advise new forms of career are now available that may involve (limited) upward movement, job change, job enlargement, job rotation and movement between organisations. For them, these new career forms offer more realistic and exciting options for individuals who adequately plan their careers to fit a turbulent environment where organisations no longer guarantee upward mobility or job security. Benefits are said to accrue to individuals, organisations and wider society through 'proper' career planning (Greenhaus & Callanan, 1994). Individuals may plan their careers to match their own aspirations, values and lifestyle needs. Organisations gain through better fit between employees and job requirements. Wider society benefits through productivity gains and a citizenship engaged in meaningful work that fits their life paths.

Yet individuals are invited to plan their career within a wider context of economic change, job insecurity, decreased wages and conditions, and erosion of social safety nets. We are not invited, for example, to challenge the appropriateness of current structures. Thus contemporary career discourse may be viewed as an extension of disciplinary techniques designed to normalise behaviour and attitudes to accept uncritically the wider political and economic changes resulting from globalisation and flexibility strategies as natural and inevitable. The next section briefly outlines Foucault (1977) and Rose's (1989) arguments for the development of disciplinary control.

From discipline to self-discipline

Foucault (1977) and Rose (1989) argued that control of society may be achieved through disciplining individuals through complex but related sets of processes. In *Discipline and Punish*, Foucault (1977) drew upon Bentham's ideal panoptic prison to offer a metaphorical space to create a disciplined society. Foucault argued the practices of hierarchical surveillance, normalising judgement, and examination represented new techniques to control populations through minute control of individuals. He argued that the applications of these practices created upon individuals 'the docile body'. He suggested creating docility represented the 'discovery' of the body as 'an object and target of power'; docile, the body may be 'subjected, used, transformed and improved' (Foucault, 1977, p136). He acknowledged that discipline increased individual utility through increased productivity and led to wider societal improvements as indicated by improved health and wellbeing. Yet he suggested discipline decreased political autonomy as individuals became obedient to the will of others by learning techniques prescribed for them, thus rendering themselves docile (Foucault, 1977).

While Foucault's analysis is insightful, his argument focused upon creating discipline through hierarchical relationships. The application of discipline through hierarchical relationships seems less relevant in contemporary society. To this end, Rose (1989) has extended Foucault's work by suggesting in contemporary society that the creation of discipline increasingly involves individual participation in the process. Rose (1989) suggested that discipline is created through the application of two related processes of disciplinary techniques (in Foucault's terms) – 'technologies of the self' and 'techniques of the self'. Techniques of the self involve the inter-relationship between government, organisations and experts in creating discipline and self-discipline in contemporary society. Rose suggested that governments of various political affiliations have concerned themselves with managing the very 'inner-self' of citizens by acting upon them at a distance through organisations and experts in order to achieve certain political ends. He contended that governments manage the subjective capacities of citizens through a process of making abstract speculations about issues of concern, devising political strategies to achieve certain goals, and then creating institutions (and organisations) that have the express aim of regulating the behaviours of citizens through managing their very subjectivity.

Rose (1990) argued that within this process, governments manage subjectivity at a distance through organisations and that organisations 'have come to fill the space between the 'private' lives of citizens and the 'public' concerns of rulers' (p2). Organisations as diverse as hospitals, schools, prisons and factories have engaged in managing human forces and powers in order to achieve the goals and objectives of various institutions and the state (Rose, 1990). Rose maintained that the management of subjectivity is carried out within the confines of superior/subordinate relationships (doctor/patient, teacher/pupil, warden/inmate, manager/employee). In this relationship, the superior is charged with achieving the goals of the institution in part through managing the subjective self of the subordinate. More recently, however, Rose (1990) argued that 'experts' are increasingly involved in managing the subjective capacity of individuals. He documented the growth in professional groups:

> ...each asserting its virtuosity in respect of the self, in classifying and measuring the psyche, in predicting its vicissitudes, in diagnosing the causes of its troubles and prescribing remedies (1990, pp2-3).

Rose termed these professionals the new 'expertise in subjectivity' and included psychologists, social workers, personnel managers, probation officers, and occupational psychologists. According to Rose (1990), experts in subjectivity:

> ...[base] their claim to social authority upon their capacity to understand the psychological aspects of the person and to act upon them, or to advise others what to do (p3).

Through techniques of examination, normalising judgement and surveillance, psychological scientists have produced a knowledge of individuality. The expert makes visible desirable norms, values, habits, or capacities (Rose, 1988). Individual behaviour may be compared with these norms and values and their variance may become the target of discipline. Thus, Rose (1988) contended the management of subjectivity can be better thought of in terms of 'disciplining difference'.

Rose maintained that the disciplinary process is completed when individuals apply 'techniques of the self'. Thus, individuals learn what is desirable, normal, valuable, and then create themselves in such a prescribed image of the self. Thus it is 'techniques of the self' that facilitates the creation of compliance and normalisation in contemporary disciplinary societies. Lynch (1985) argued that such a person becomes a 'docile object [who behaves] in accordance with a programme of normalization' (pp43-44).

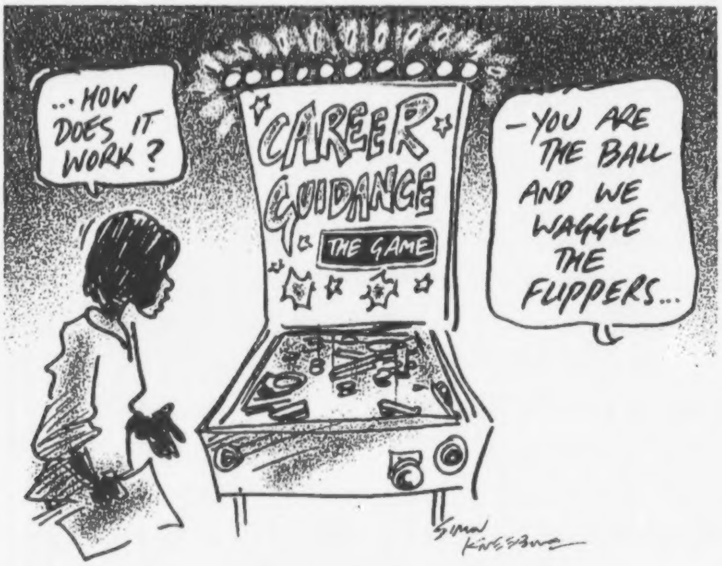
The contributions of Foucault and Rose may provide some useful insight into re-viewing contemporary career discourse as an extension of the disciplinary apparatus within contemporary society. In the following section, the roles of career guidance counsellors and career styled self-help books are discussed. It is argued that career counsellors and self-help books are becoming a new category of 'experts in subjectivity', as identified by Rose.

Career guidance and self-help books: the new experts in subjectivity?

Watts (1997) noted career guidance is a growing profession with career counsellors and consultants working in private practice and government-funded organisations. The career industry draws upon changes in work characterised by restructuring, downsizing, flatter organisation structures, flexibility, and global competition and technological advances as reasons why individuals need to recreate themselves to maintain employability (Kanter-Moss, 1989; Greenhaus & Callanan, 1994; Handy, 1994; Hall & Associates, 1996). They offer their services to facilitate self-recreation.

Hall and Associates (1996) noted that typical career guidance sessions assess clients using a variety of techniques including interviews, psychological testing, and aptitude and ability tests. These techniques at once place clients under surveillance and examination. Once assessed, counsellors make normalising judgements about clients in terms of their personality, abilities, attitudes, behaviours, values, and characteristics. Individuals may then be matched to 'suitable' career options. Career counsellors may then help create a career management plan and offer advice on how to achieve career goals. Advice might cover such issues as curricula vitae, training requirements, writing job-application letters, conduct in interviews, appropriate dress, changing personal attitudes, behaviours and values, and how to take responsibility for managing one's career.

Thus the career counsellor normalises individuality through the process of soliciting information from clients, repackaging this information as a supposed picture of the 'self', and presenting this 'self' back to the individual. This 'self' may then be manipulated and changed by acting upon the advice of the expert and doing things to the 'self'. Clients who uncritically accept the advice of career counsellors and make changes to themselves to pursue a 'realistic' career have become docile and amenable to do things to themselves in the pursuit of recreating themselves in an image provided for them.


... HOW DOES IT WORK?
CAREER GUIDANCE
THE GAME
- YOU ARE THE BALL AND WE WAGGLE THE FLIPPERS...

Garsten and Grey (1997) agreed with Rose's analysis of the growing importance of experts in meaning-creation in contemporary society. However, they argued that for many people, access to experts is discontinuous and even marginal to their everyday life experiences. Rather, they suggested people have greater exposure to expertise through the media and through 'self-help' books. They argued that 'self-help' and 'how-to' books offer guidance on how to relieve anxiety in the post-modern era, an era characterised by organisational restructuring and the resulting labour flexibility practices. Similar to 'live' experts, they noted 'self-help' books offer advice, techniques and strategies to come to know oneself and how to change this 'self' to become more effective in an ever-changing world.

Embedded in self-help books is a claim that individuals can control themselves and to some degree, their environment. However, Garsten and Grey (1997) noted such books typically ignore the restraining contextual environment within which people live their lives. As such, they argued that self-help books not only guide individuals to manage their soul in terms of Rose's (1990) analysis, but the disciplinary nature of these books becomes clear in a Foucauldian sense in that:

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> ...for all the humanistic talk of recognising the inner self and knowing oneself the reality is to validate a particular version of the self which is congruent with demands of organizational life (Garsten & Grey, 1997, pp222-223).

While these authors' discussion focuses on managerial self-help and how-to books, their argument is equally compelling in relation to career management texts. Carson and Phillips-Carson (1997), for example, have found over 3,000 books published on career in the last decade, of which Hall and Associates (1996), and Greenhaus and Callanan (1994) are typical examples. In addition, access to similar advice, strategies and frameworks can be found on the World Wide Web. Garsten and Grey (1997) argued that career management self-help texts:

> ...must necessarily be regarded as an exercise in normalization: plainly the very notion of managing a career let alone prescription of the way to do it reflects particular ways of apprehending the world and one's place in it (p217).

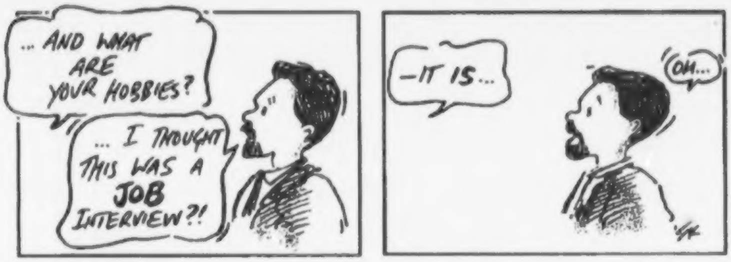
Thus the career guidance industry and career management self-help text may be viewed as a new family member to the 'psy-sciences' who specialise in fabricating individuality around the ever changing 'needs' of global neo-liberalism. These experts help create a suitable workforce equipped with the right skills, attitudes and values for the modern world of work, that of accepting personal responsibility for their own employability and welfare provision. By focusing on the individual, they help to obscure the structural constraints or boundaries to managing one's career. Thus the new career expert may be viewed as providing a particular disciplinary and normalising function within contemporary society, that of facilitating the acceptance of global changes as manifest in the day-to-day lived experiences of individuals. While career experts and self-help texts may be viewed as normalising agents, the practices internal to organisations are increasingly supporting contemporary notions of career and individual opposed to organisational responsibility for employment. The next section discusses how the application of contemporary career discourse within organisations may be viewed as an application of discipline.

Discipline through career discourse

Fox (1989) argued that organisations are managed around panoptic techniques where senior members of organisations observe, judge and examine junior members' behaviour, ability and attitudes without being seen to do so. Disciplinary techniques may be operationalised to make decisions about recruitment, selection, retention and discontinued employment. The construct of contemporary career may be viewed as providing a set of parameters when making such decisions.

Greenhaus and Callanan (1994), for example, discussed the importance of selecting the 'right' person for an organisation. They suggested selection decisions ought to be based on the 'total person', 'fitting' the organisational culture and job requirements, and ensuring a match between individual career aspirations and organisational career opportunities. They argued this 'fit' might be determined by measuring recruits' knowledge, skills and abilities; matching their personal values with corporate values; and matching individuals with the organisational culture. Selection techniques designed to determine 'fit' include interviews, resume and reference checks, psychological testing, cognitive and ability tests, personality tests and interest tests (Newell, 1994).

Grey (1994) illustrated how the application of disciplinary techniques within the recruitment and selection phases individualised new recruits by making them visible, yet successful applicants were describable in a homogenous way. As he noted, successful applicants in his study had obtained 'A' grades in their degrees, had evidence of non-academic activities, were demographically similar (typically white, male, middle class and aged between 21 and 22 years), and possessed the right personality and cultural knowledge. The right personality was defined by the organisation and included possessing the ability to accept routine tasks in the short-term, and having the potential to present themselves well to clients and partners of the firm in their future career. Grey (1994) described the right cultural knowledge as including 'beer, football, Australia, fitting in, an ethos of work hard/play hard, *lack of critical reflection*' (p485, emphasis added). Thus new recruits seemingly possessed what Foucault (1977) termed the 'value-giving' norms of the institution. That recruits appeared to lack critical reflection is reflective of Clegg and Dunkerley's (1980) argument that employees already come equipped with an ideological repertoire that is supportive of organisational goals. Grey (1994) thus described a selection process that targeted docile-utilisable individuals already normalised to accept uncritically the values of the institution as fitting with their own needs, values and aspirations.


... AND WHAT ARE YOUR HOBBIES?
... I THOUGHT THIS WAS A JOB INTERVIEW?!
–IT IS...
OH...

Once employed, hierarchical surveillance, normalising judgement and examination continue through the application of formal and informal performance appraisals (Barker, 1993; Grey, 1994). Fournier (1996) argued that performance appraisals inscribe individuals making them visible to management. She suggested that through performance appraisals individuals are:

> ...'normalised' by being written onto a disciplinary matrix of competencies and performance criteria. The subject becomes visible and known through traces of competencies or objective achievement (p 3).

This knowledge leads to particular power relationships. Successful learning may be rewarded; the unsuccessful may be transformed with training and development. Yet others may be punished by loss of promotion opportunities, pay rises or exit.

Carson and Carson-Philips (1997) suggested that the application of the construct of career may be a useful technique to 'counsel' out employees experiencing career entrenchment. They suggest career entrenchment is evident when individuals feel trapped in their career, are no longer satisfied with their work or lifestyle, and have withdrawn commitment to the organisation resulting in productivity decline. For Carson and Phillips-Carson (1997), the challenge with career entrenchment is 'how to encourage those who are attached to their careers, and as a result, their organisations simply for 'economic' reasons to move on' (p 75).

While disciplinary techniques are evident within organisations, the ability to constantly survey and examine employees is limited. Yet, there is evidence to suggest that individuals apply the construct of career to monitor their own behaviours. The use of career as a frame for disciplining the self is discussed in the next section.

Disciplining the self through career

Savage (1998) argued the purpose of creating the bureaucratic career was precisely to overcome the inability to constantly supervise workers in the developing railway industry. For him the bureaucratic career provided clear sets of rules that, if followed, could lead to a 'career'. Thus Savage suggested self-managing behaviour has been evident since the development of the construct of the bureaucratic career model. Grey (1994) argued that the construct of career 'offers a relatively well-defined scenario within which individuals may develop, express and create themselves' (p481). Self-management or self-governance around a construct of career can incorporate all aspects of a person's life. The act of self-management involves self-interpretation of 'gaps' or 'deficiencies' in behaviour as a lacking in oneself and then taking responsibility for 'closing the gap', or suffering the consequences of non-compliance. Such persons are already amenable to do things to themselves to achieve their own career goals, to create themselves to fit a particular career image. However, Grey (1994) and later Fournier (1996) argued that before individuals will manage themselves, they will already be constituted in a particular way through the new career discourse. For Fournier, the new career discourse constitutes individuals as entrepreneurs and consumers.

Fournier (1996) believed by fabricating the self as an entrepreneur and consumer, the self becomes an object to be known, assessed and calculated upon in light of achieving the desired career, lifestyle and future return on one's investment. Choosing the right career thus enables lifestyle choices to be fulfilled. Fournier argued the new career discourse seduces subjects by providing images of what we can be through offering endless opportunities to realise ourselves by re-inventing ourselves. The new career is presented as 'boundaryless' and unrestrained by old bureaucratic rules, therefore our career is what we make of it, and in this sense career becomes a vehicle to transform ourselves into a desirable other (Fournier, 1996). Fournier and Grey (1994) both argued that through fabricating ourselves around a particular notion of career, disciplinary techniques facilitate the act of self-management.

Grey (1994) illustrated how performance appraisals helped (re)form subjectivity by providing new recruits with a picture of what sort of person would have a successful career. He noted that within performance appraisal, recruits learned the need to display enthusiasm and commitment, and that some actually became enthusiastic and committed. Thus, Grey argued, appraisals appeared to provide two functions in the organisation. The first was to produce subjectivity through disciplinary power in the Foucauldian sense. The second, to act as aids or adjuncts to career by becoming a site where new lessons about appropriate (career creating) behaviour could be learned. Thus, Grey argued disciplinary techniques are not wasted on the already docile subject as their career goals are reaffirmed and they learn new lessons on how to achieve these goals through self-management.

While Grey (1994) illustrated how employees may reinterpret performance appraisals as aids or adjuncts to career, Fournier (1996) illustrated the implications for those who have not 'bought' into the new career discourse. Fournier found a group of employees who viewed the current flexible work environment, characterised by flatter organisation structures and numeric and functional labour flexibility, as creating additional boundaries to their pursuit of career. For this group, performance appraisals were seen as managerial disciplinary techniques designed to control and manipulate workers, and job enlargement was viewed as exploitation. However, Fournier argued that people who resist the new career discourse play an important role in reproducing and affirming it for those who have adopted it. She suggested the actions of resisting employees refusing to take charge of their own destiny may be made visible to those who are assimilated within the new career discourse. Resisters may be recast as 'failures' in the project of self-management, and their lack of career progress the visible manifestation of their failings. Structural constraints perceived by resisters become obscured through a discourse of individual failing to take responsibility and to take charge of one's career.

While career management and development planning may be viewed as a useful guide to aid and facilitate choosing the 'right' job to satisfy an individual, in light of the current employment context such a perspective is challenged by a critical reading. The next section offers some concluding thoughts of career discourse as a normalising process within the current global environment.

Normalising globalisation through career discourse

Contemporary career theorists proclaim within the new world of work there are new opportunities for 'boundaryless' careers (Arthur, 1994) where the 'protean careerist' (Hall, 1996) can create meaning for the self through properly managing their new and more exciting individually-driven 'portfolio' career (Handy, 1994). Yet not all career theorists are convinced of the 'boundarylessness' expressed within contemporary career discourse. While drawing on the wider structural changes associated with globalisation, restructuring, downsizing and technological development as providing the impetus for re-evaluating what it means to have a career, contemporary career discourse seldom, if ever, draws attention to the structural boundaries and 'negative' consequences of these practices. The global widening gap between rich and poor, downward pressure on incomes, decreasing health and safety standards in employment, increased crime, increased exploitation, marginalisation and job insecurity, declining health statistics and environmental disaster are albeit ignored within the new career discourse. Structural causes of differentiated access to employment opportunities resulting in over, under and unemployment are re-framed as individual outcomes of properly or inappropriately managed careers. In concert with these workplace changes we have witnessed decreased government spending on welfare provision for citizens.

Pringle and Mallone (2001) drew attention to social structural constraints that continue to be silenced within the new career discourse, the same constraints they argued limited the 'career progression' of many individuals under the traditional bureaucratic career model. For them, gender, race, ethnicity and accumulated skills are still neglected within the individualistic discourse of contemporary career theory. They suggested sexism, racism and lack of accessible educational opportunities continue to pose considerable social barriers to the ability for many individuals to manage their own career.

Because we have argued there are structural constraints preventing many individuals from managing their own careers in accordance with contemporary career discourse, this discourse may be viewed in a new light. Rather than a functional set of instructions to guide individuals through the new terrain of work, contemporary career discourse may be viewed as a 'moral' project with the aim of re-fabricating individuality. Taking such a perspective allows contemporary career discourse to be viewed as a normative model that may facilitate the production of compliance, consent and assimilation of individuals into the wider socio-political context of global neo-liberalism. Taking such a view allows contemporary career discourse to be seen as part of a moral project that explicitly and implicitly guides individuals to act upon themselves to better fit the contemporary world of work. Thus the contemporary career discourse invites us to see ourselves as a potential other, one that can and ought to recreate the self in a new image.

The image presented for us is an independent, atomised individual who necessarily needs to become flexible, multi-skilled and able to take charge of, and be responsible for our own employment and welfare needs. Thus, citizens and workers must learn what is necessary to stay employed, and that unemployment is an outcome of personal and not structural failings. The career discourse does not, for example, invite us to view the current employment environment as a contemporary political creation. Nor are we invited to question this creation or offer alternative ways of being. We are to view the current environment as inevitable and 'quasi-natural'. By acting upon ourselves we explicitly or implicitly help actively to create and uphold the new system.

Savage (1998) suggested the very creation of the bureaucratic career may be viewed as a moral project designed specifically to motivate employees to act upon themselves and to monitor their own behaviour. Savage suggested that creating a moral project around career progression fulfilled the control needs of management at a time when direct supervision became increasingly difficult due to organisational growth. Thus, individuals managed themselves in accordance with the 'promise' of career progression. Contemporary career discourse still appears to 'act' on the self, albeit offering a different picture and possible trajectories of career.

Yet contemporary career discourse extends the project beyond the boundaries of the organisational context. It is not enough to act upon ourselves to 'fit' the needs of our current employer and hence increase our chances of pursuing a career within our current place of employment. We must continually upgrade ourselves so we are ready to move to new forms of work and to safeguard ourselves against unemployment. If we become unemployed, we are solicited to believe it is because we are lacking or failed to project ourselves in the right direction. Yet, all is not lost, as there is a growing body of career experts who are willing and said to be able to advise us on how to re-form, re-fabricate and fit.

Taking such an approach enables contemporary career discourse to be viewed as part of a complex disciplinary matrix that has the effect of normalising the day-to-day lived experiences of individuals under the umbrella of globalisation and flexibility. For those who succeed, contemporary career discourse offers a seductive reassurance that they have done so through personal effort. For those who experience diminished life chances or become victims of structural changes, contemporary career discourse offers an equally compelling explanation: that of individual failure. Failure to negotiate and recreate the self is punished by diminished access to the means of survival. Such a view deems contemporary career discourse as problematic. For contrary to Foucault's analysis that the application of the disciplines improved wealth, health and wellbeing of citizens in the 17th and 18th century, global neo-liberalism has undermined the material circumstances, health and wellbeing of many citizens.

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3 Mental health promotion and work: Rumbalara community's roundtable discussion 2002

Rosemary Hoban and the Rumbalara community[1]

Context

> The relationship between socioeconomic status and health is well established, with people at the lowest socioeconomic levels experiencing the highest rates of illnesses and death (ABS, 2001, p10).
>
> While poverty, unemployment and limited access to adequate housing have a significant impact on the health and wellbeing of the general population, Aboriginal people's experience of these issues is disproportionately high (VicHealth, 1999, p41).

Aboriginal people are less likely to be employed and less likely to have post-school educational qualifications, and also have lower personal and household incomes than other Australians (Australian Institute of Health and Welfare, 2000).

Introduction

Rumbalara, which means 'at the end of the rainbow', refers to the Koori community in the Goulburn Valley area of Victoria, particularly around Shepparton and Mooroopna. It was the name first given to the site, which was developed as a transitional housing estate for Aboriginal people in 1954. In the 1960s, Rumbalara ceased to operate as a housing estate. In the early 1970s it was developed into the administrative centre for the Rumbalara Aboriginal Cooperative, which runs the community's health, social and cultural heritage programs. It has also become the centre point for the political aspirations and policy development for Indigenous people in the Goulburn Valley. The Rumbalara Football Netball Club was also set up in the 1970s.

Most members of the Rumbalara community are Yorta Yorta people, the traditional owners of the Goulburn Valley area, which is home to the largest Indigenous population outside of Melbourne. A roundtable discussion about mental health and work issues was organised with representatives from this community.

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[1] This Rumabalara Project was a collaboration involving the sharing of thoughts by many. 'I had the privilege of giving them form': Rosemary.

Roundtable participants:
Paul Briggs: Community leader and President of the Rumbalara Football Netball Club
Kaye Briggs: Coordinator of the Rumbalara Birthing Program
Daniel Briggs: Mental Health Team Coordinator, Rumbalara Cooperative
Joyce Doyle: Coordinator of the Rumbalara Football Netball Club's Leadership and Mentoring Program
Katrina Alford: Department of Public Health, University of Melbourne
John Murray: Drug and Alcohol Worker, Rumbalara Cooperative
Tanya Garling: Koori Project Officer, School of Rural Health, Shepparton

These people gathered to talk about the role of work and how it impacts on their lives and the lives of others in the close-knit Rumbalara community. Their work settings vary from leadership positions within the sporting organisation, to jobs in the health services and the resource centre.

There is a sense they have been here before, talking the same talk to different people. Other non-Aborigines have visited before and questioned, determined to explore issues and hopefully find solutions to problems. They leave and document their findings. Most are well meaning. Still, these people generously share the meaning of work, the challenges and constraints of living and working together, and issues of contention.

After a couple of hours the discussion ended, and the community members headed back to their work. The issues were suddenly academic. In this community the work has to be done. These people do it. Ironically, the workload they take on binds them to each other and to the community. Sometimes it burns them out. Sometimes it drives them away. Here are their views about work and its effects on their lives.

Defining work

Kaye Briggs has managed the community-controlled Rumbalara Birthing Program for a decade and while her clients are Kooris, she works with many non-Aborigines in a range of medical settings. She has also worked for non-Aboriginal agencies and knows the difference in the work environments. In general, the expectations of peers are also remarkably different. You start work Monday morning and you finish Friday evening.

If you are asked to work longer hours you are remunerated for overtime or 'on call'. Leaving work at work and enjoying home time is not just unacceptable; indeed taking work home is often encouraged. Within the Rumbalara community, there's no walking away from work; home is work and work comes to your home. It's much more than just demand and expectation from community members; it's an emotional obligation. And there's an acknowledgement among these people that the need matches the expectations.

Paul Briggs is a community leader, sometime Rumbalara footballer, a father and an advocate on innumerable state and national committees and boards. His paperwork has flowed into his car, which now operates as a mobile office. More than that, Paul's home is a community resource. Paul says he has trouble establishing boundaries between work and home, and therefore understands the community has even more trouble recognising such boundaries:

> *It is difficult for me to define personal space or family space. People expect the family to be accessible. It's a mutual obligation though, because I expect that of myself. It's also a cultural obligation to look after your family, extended family and community, and so the work side of things just carries over.*

Community member Joyce Doyle agrees that separating work and play is impossible in community life. It is one reason the 'burnout' factor hits many people at Rumbalara and forces them to start moving in a different direction. Joyce, a trained primary school teacher, has worked for the Rumbalara community in a range of management and coordinating positions. Three months ago she started as coordinator of the Rumbalara Football Netball Club's leadership/mentoring program (funded by VicHealth), which will endeavour to recruit and train about 20 members of the senior football and netball clubs. These people will be expected to act as community leaders and mentor younger people who may in turn become community leaders. As Joyce says:

> *I move in and out of positions to survive because of the pressure that comes from the community, but also because the services are so under-resourced. I also leave, sometimes to go to Melbourne and gain new skills, so that I can bring something back to the community.*

She goes on:

> *Look the pressure is great, but this is my home. I know every single person who I work with and they are the same people I socialise with at the club. In fact I am related to a lot of them. I keep coming*

> *back because you have to come back if you want the community to survive for yourself, your children and your grandchildren.*

Community controlled organisations, like the Rumbalara Co-op and sporting clubs, have no enterprise agreements. While Daniel Briggs is playing sport, no one is 'on-call' or paid overtime to cover him and to deal with ongoing mental health problems in the community in his absence. There is no structure in place, Daniel says, to learn how to manage the pressure and demands of work at Rumbalara. Paul Briggs agrees with Daniel that the community needs to deal with this ongoing stress, but no grand structural overhaul in isolation will solve the problem:

> *I play football with Rumbalara and sometimes in the middle of footy training I have a bloke talking to me about some of the problems he is having. I don't turn away from him. I tell him I will try to organise from him to see someone as soon as possible. He doesn't see that my recreation time is not for dealing with his problems and I understand that, but it makes it difficult.*
> **Daniel Briggs: Coordinator of Rumbalara's mental health team**

Paul says:

> *The notion of award conditions and a 38-hour week doesn't fit here. The 'mainstream' workplace benchmarks don't fit into the community-controlled structure. I know it is not very strategic in the way it operates, isolated from services and processes of government departments and bureaucracies.*

He adds:

> *In this community, work doesn't have the same meaning as a job that has a start and finish. It is a way of life.*

Value of work

These people (at the roundtable discussion) perceive work in the non-Aboriginal world to mean a chance to succeed and success is a house, a car, and other consumer goods ranging from a DVD player to the latest electronic toys for children. If you don't have a job, particularly for men, there's a stigma. You are lazy or a dole bludger who, in the case of a man, can't look after his family.

Paul Briggs says most Kooris prioritise the financial aspects of employment in a way that is different to how non-Aborigines appear to. In fact, if paid employment jeopardises the care a person can give to their

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family, then it is seen as having limited value. The most valuable work an Aboriginal person can do is to care for their family. Holding the family together is paramount. Researcher Katrina Alford (non-Aboriginal) believes non-Aboriginal Australians could learn a great deal about family values and support from Koori communities.

> *When we sit around telling yarns, we always seem to get talking about the old days when things were really good. Everyone laughs and says the best days were when we were on the missions. Not because of a lot of stuff about the missions, but because we were together. Families were together. The sense of belonging and cultural support was very strong. It's funny, isn't it? The missions are now thought of as the good old days.*
>
> ***Community leader Paul Briggs spent most of his first 18 years on the Cummeragunja Mission, which was established in 1888***

Indeed, paid employment can place a great strain on many Kooris, depending on the workplace and workmates. Everyone at the table knew of particular workers who had spent many years in mainstream firms, but eventually left these jobs to escape the racism that confronted them each day. Working in the white community is okay, but the mainstream view seems to be 'leave your Aboriginality at the door', Paul says.

Paul says many Kooris in the Goulburn Valley face barriers to work, which include the declining number of unskilled jobs, and poor school retention and skill levels. These problems are exacerbated by racism. Machinery is now displacing many Kooris. The Goulburn Valley fruit canneries, which once offered ideal job opportunities for local Kooris, now require some familiarity with computers. Paul believes the loss of work opportunities has hit Koori men dramatically and they are trying desperately to assert their presence in the community.

Adrian Appo (unable to attend the roundtable discussion), the founding chairperson of the Koori Economic Employment and Training Agency (KEETA) which began seven years ago, says unemployment is around 80% in the Koori community. As well as influencing the living standards of many Koori families, Adrian believes the unemployment factor also impacts on retention rates of Kooris in the mainstream education and training systems.

Less than 10% of Kooris in the Goulburn Valley are enrolled in an education or training program and there are only about 170 Indigenous students at the Goulburn Ovens TAFE. Huge numbers of Koori children

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have dropped out of school before they are 15 years old, typically around 13 years of age. Adrian says:

> *Young people look around the community and believe that there are no jobs for Kooris so they don't have the incentive to go on with school or training. They think there is nothing at the end for them anyway. But we are working to change the attitudes of non-Aborigines and Kooris.*

Adrian says a recent project developed locally called 'ladders to success' placed 37 people into employment with a 97% success rate. This was linked significantly to members of the Rumbalara Footy Club as a part of their holistic health approach.

Kaye Briggs sees great value in her work with the birthing program because it bridges the gap and develops some cultural understanding between pregnant Koori women and mainstream medical and health professionals. Before the program began 10 years ago, it was difficult to get a Koori woman to see a doctor or any health professional until she presented in labour. Now, most of the women have five to seven antenatal appointments, which dramatically reduces the risk of difficulties during birth. Kaye believes programs like the Rumbalara Birthing Program can help impact on Koori infant mortality rates, which are 22 infant deaths per 1000 births, significantly higher than the figure of 10 per 1,000 for other Australians (AIHW, 2000, p209). Her caseload can be as high as 30 and she is currently supporting 15 pregnant women of varying ages.

> *I was called to see a girl who the doctors said needed to stay in hospital because she was having difficulties with the pregnancy. But she wouldn't stay and wanted to go straight home. The doctors got angry and said she was irresponsible and didn't care about the health of her baby. I explained to them that she lived with her extended family and she was responsible for this family. Her children were waiting at home for her to cook their tea and look after them. I explained that she had never been in hospital and had never been away from the big family. This girl was responsible for her family as well as the unborn baby and she was in a very difficult position. She was scared of the hospital staff and intimidated by what they were saying. At times like this I can be a voice for these young women. That's why I work in this community.*
>
> ***Kaye Briggs, Coordinator of the Rumbalara Birthing Program***

Within the Rumbalara community, work is viewed in so many ways depending on the job, resources and support. Clearly work is seen as having

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great value if it can add to the stability of the community or develop the strengths of community members. Work however, for many Kooris, is a threat to their mental health if it exposes them to racism or isolates them from their family and community.

Community work and life

John Murray was driving around Shepparton at 2am a few weeks ago trying to find accommodation for a young Koori mother who had been 'knocked around'. She had knocked at his door in the middle of the night and he did what he has done many times before in his 15 years as a drug and alcohol worker. John is comfortable with the convergence of life, home and work, but knows the price you pay. He has 'burnt out' five or six times and has often wanted to walk away for good from his job as an alcohol and drug worker. Instead of walking away, he has taken a few holidays and returned to his job, and is now the longest serving Koori drug and alcohol worker in Victoria. John is as passionate about the Rumbalara Football Netball Club as he is about working with the community's young people. John says:

> *Before Rumbalara joined the league I would gather up a busload of kids on the weekend and take them to a footy match. I concentrated on trying to prevent the drug abuse by giving them something else to get involved in.*

He adds:

> *Now the club supports what I do by supporting young people.*

Further:

> *I know personally every single person I deal with in my job. I see them at the footy club and socially, and I help them then if I can. In a way the footy club, with all the programs they have going, takes the pressure off me a bit in my work.*

While some community members strive to put space between the community's problems and their home life, John has accepted his work as a very big part of his life. If he can help any young community members with alcohol or drug misuse, he will. He has seen too many families torn apart and turned upside down. John has experienced the tremendous support of his community, particularly when his brother died a few years ago. John says the benefits of working and living in the Rumbalara community far outweigh the difficulties:

> *In 15 years I have seen the young boys I have worked with grow into good men with small children of their own now. I see them as*

> *part of this club and being supported by the club and their extended families. Some of them I thought might go down, but I look at them now and I am proud of them.*

Life, work and play

So much of the life and heart of Rumbalara revolves around the football and netball clubs. It's here that workers play and socialise with clients. It is through the clubs that myriad mental health and wellbeing programs have been borne and nurtured. It is also through the club that much conflict and claims of racism have developed in recent years. This impacts on Rumbalara workers who are also key members of the club. In recent years there have been attempts to expel the club from the Goulburn Valley League in which they play.

Daniel Briggs plays football for Rumbalara and at least one of his team-mates is a non-Aborigine. This man, Daniel says, has lost friends over his decision to play with Rumbalara. Joyce Doyle has heard the player called a 'nigger lover' for playing with people too often characterised as 'drunks' and 'unemployed no-hopers'.

> *Tomorrow we are going to a small town nearby to play football and netball. They get very churned up about Rumbalara teams, made up of Aborigines coming to their town. But it is good because it forces people to talk about and address issues of racism. It is also stressful for teams to come here to Rumbalara to play. They have to face their fears, stereotypes and bias. Thankfully, most are coming through the stereotypes, but it has taken five years. It is also a great learning for our people who do not normally associate with whites.*
>
> **Paul Briggs, President and sometime player with the Rumbalara Football Netball Club**

Ironically, Daniel, Paul and others are usually involved in the aftermath of this racism in sport. They are the community leaders called upon to try and heal wounds, broker talks, organise reconciliation forums or smooth over tensions within the club. Again, the nexus between work and play is impossible to break.

Tanya Garling is a young Aboriginal and Torres Strait Islander woman who has worked in different settings in Shepparton and who recently returned after a few years working in Melbourne. She describes her current

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work with the community as 'different' than previous jobs in non-Aboriginal workplaces. Many of her friends are non-Aborigines and very few were happy about her new job that involves working with the Koori community. Tanya said:

> *If you work in or with the Koori community your skills are not valued as much as they would be in the non-Aboriginal community. It can even be seen as a step backwards.*

Tanya went on:

> *It was an eye opener for me to discover how many people frown upon any association with Rumbalara, whether it is work or sport ...this is my first season playing netball with the Rumbalara Football Netball Club and I have discovered the stigma attached to playing there. Before this I had only ever played in non-Aboriginal teams.*

Leadership

The conversation around the table faded away when the topic turned to leadership. Joyce Doyle's new position is all about nurturing new leaders in the community. 'I don't really know how I can 'sell' the idea of leadership', Joyce says.

> *I have to train these young people in as many areas as they need help. That might be public speaking, writing or whatever. It is about offering as much support and training as we possibly can, because the pressures on community leaders are out there and I can't take them away. I have to help these people learn to cope with the pressures.*

The leadership program, which has more than 12 months funding from VicHealth, is about nurturing leaders and encouraging teenagers to reach for an attainable goal.

Daniel Briggs' job has forced him into a position of leadership. He needs to be seen as a leader if he has any hope of gaining credibility among the mainstream health service providers he deals with most days. But most importantly, Daniel needs to be credible in order to help deliver programs effectively to his own community. Daniel says:

> *I know that if I was out every Saturday night getting drunk and acting inappropriately, people who might want to use the mental health service would look at me and think otherwise. While I don't do any counselling, I am the first point of call. And if police had to put me in the lock up all the time, word would soon get around.*

Daniel, like so many 'leaders' or role models in the Rumbalara community, is under pressure from within their community and from external forces, many of which have stereotyped Kooris as drunks.

Kaye Briggs says her family is like most, especially within the Koori community. There are domestic problems, difficulties with children, meals to cook, relationships to balance and a home to keep running. But the community still expects her and Paul to be always available:

> *Sometimes I think people forget we have lives going on, often dealing with the same problems and issues they are. They expect us to be iron people, always responsible for the community. Sometimes it is hard enough being responsible for your own family.*

Adrian Appo (a Murri from Queensland who has lived in the Goulburn Valley for many years) says leaders in Aboriginal communities are usually stretched to the limit, often to breaking point. Once they have developed some expertise, a profile, or position within the community, they are asked to sit on boards and participate in forums and committees throughout the country. As he says:

> *Sometimes while we are trying to solve the problems of the community, we run the risk of creating problems for our own families because we are out every night on committees and never home when our children need us.*

Adrian says:

> *Once you have a work profile it is impossible to be seen in any other way. Sometimes when I take my wife out to dinner, someone will see me in the restaurant and come in to discuss an issue. Now, I try and avoid places where we will be seen and when we have holidays, we leave town. I have learned to say when 'enough is enough', but I know others who just can't.*

He goes on:

> *Leaders also face the prospect, that in mixed gatherings, we carry the weight of our community on our shoulders. When we attend meetings we are often expected to be experts on every Indigenous issue as well as the fields we work in. This extends to every Indigenous person in a mixed workplace, and it is the reason that some, where they can, choose not to disclose their Aboriginality.*

Kaye Briggs hopes the community's younger members see her position as a possible career path that is well within their reach:

> *I think young people can look at me working with the Birthing Program and maybe become interested in nursing. They can see me talk to an obstetrician and get respect.*

She says:

> *I hope my work inspires them to finish school and aim for something.*

Paul agrees the pressures of leadership are immense and he understands the reluctance of many Kooris to move from being leaders within the community to taking a leading role with government and bureaucracies. More than once the pressures have threatened to swallow him up. One might well ask:

> *What makes Paul and others like him stay and work in their community?*

The response to this question, and indeed the roundtable discussion, is well summed up by Paul:

> *It is a great thing to feel you can create a change for the better for your family, extended family and community. And we are not going anywhere, we are on our land and we are staying here. We have been working on this relationship for two hundred years and we have to keep dealing with the problems. We live in our country and we have to face issues. So we just keep facing them the best way we can.*

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4 Working women's health

Thea O'Connor

Increasingly, progressive organisations are investing in workplace health promotion to minimise sick days, enhance workers' morale and position themselves as employers of choice. This article provides an overview of some factors warranting consideration when planning a workplace health program to benefit women. Unique influences on working women's health are explored using a social model of health. For example, how does work itself impact on health, or the role of carer? And what do women themselves say they want when it comes to their health in the workplace? Workplace health programs that respond to women's unique needs are described.

Introduction

Women, who make up about 44% of Australia's paid workforce (ABS, 2002b), take more sick days than men (ABS, 2002a). Evidence of women being the weaker sex? More likely it signals our predominant work-style is still not optimal for the health and lives of working women. Companies are increasingly investing in workplace health promotion as a strategy to minimise sick days and enhance workers' vitality. For such health programs to truly affect the health status of working women, attention needs paying to both the unique influences on women's health and to what women are most concerned about. In reviewing options to improve the physical and mental wellbeing of female employees, consideration of what is already known about women's health will help program planners make an informed start.

How does gender affect health?

While there are commonalities between men's and women's health, we also know gender plays a key role in health and wellbeing outcomes. Gender has a strong influence on what type of illnesses people are likely to suffer from. Some health issues, for example, are unique to women, such as those related to menstruation, pregnancy or gynaecological cancers. Other illnesses are much more common in women than in men, such as major depression, which is twice as common (Komesaroff, 2001). Women can also experience the same disease differently to men. Ischaemic heart disease, for example, shows up differently in women and has poorer treatment outcomes (Komesaroff, 2001). The gender distribution of the workforce will therefore influence which health concerns take priority.

Gender also affects the way we are socialised regarding certain health behaviours such as eating and exercise. This means men and women are likely to experience different barriers to healthy eating and exercise later in life. Benefits from gender-sensitive approaches to nutrition and fitness are therefore likely.

There are also gender differences between men and women in health knowledge, use of health services and the way men and women like to have their health care delivered. Typically, women are more active consumers of health care services, practise more prevention, and are better informed about some areas of health than men. Such differences mean a 'one size fits all' approach to health promotion in the workplace may not generate the return on investment a gendered approach would.

Which model of health is best suited to working women?

Leaders in the field of women's health insist we need to broaden our thinking about women's health, to move it beyond a medical model that tends to focus on individualistic approaches, in particular women's reproductive organs, to a *social model of health,* which is context driven. This model recognises that health promotion efforts need to address the economic, social and cultural context of a woman's life, since it has such a strong influence on health.

A social model of health acknowledges such factors as higher income, higher education levels and even where you live seem to affect health. For example, data from Women's Health Australia (a longitudinal study on women's health conducted by the Universities of Newcastle and Queensland) show women in remote areas tend to have the same level of health as women in urban regions – despite limited access to health services and a higher proportion of Indigenous women living in these areas. City dwellers are, however, significantly more stressed than women living in rural and remote areas (Lee, 2001).

There are also significant links between employment and women's health. While there are certain conditions that can lead to deterioration in working women's health (such as time pressure, highly repetitive jobs involving exposure to occupational hazards, or dealing with the 'double shift' of work and home), Australian women in the paid workforce generally report better health than those who are not employed (Bryson & Warner-Smith, 1998). This is true for both physical and mental health. It is clear the effect is operating in two directions: there is evidence employment itself enhances health (through a combination of enhanced self-esteem, confidence, financial independence and sense of control over one's life), and also those with better health are more likely and able to be employed.

The multiple roles women play in life are also recognised as directly affecting health, especially for women who are in the roles of carer and/or worker. Results from Women's Health Australia show being a caregiver increases the risk of poorer physical and mental health. This places a lot of women at risk, as 79% of carers of both younger and older people in Australia are women (Schofield *et al.*, 1997).

Combining the roles of carer and worker also affects women's health. Emeritus Professor Lois Bryson (*pers. comm.*), who has been analysing data from the Women's Health Australia study at the Research Centre for Gender and Health, University of Newcastle, found working women aged 45–50 years tended to have poorer physical and mental health if they were caring for another adult who was disabled, sick or elderly. The study found the mental health scores of working women who also have responsibility for a child under the age of 18 at home started to decline when they worked more than 34 hours per week. Being employed while not having any children at home was associated with the highest mental health scores. Mental health scores were calculated using SF 36 – short form health survey (Ware & Sherbourne, 1992).

Improving working women's health does not, however, simply lie in reducing the number of life roles they assume. Professor Christina Lee, Manager of Women's Health Australia (Lee, 2002, *pers. comm.*) has found having too few roles isn't good for health either. Using data from the Women's Health Australia project, she examined the health of young, middle-aged and older women according to how many roles they played in life: mother, partner, worker, student or family caregiver. For the middle-aged women, those who had 3 or 4 roles had the best mental and physical health, whereas younger women reported the best health with only one role. This difference might be explained by middle-aged women having acquired better time-juggling skills with age. For both groups though, having none of these roles was associated with worse mental and physical health, than having all five roles (Lee & Powers, *in press*).

The challenge, it seems, is to help women find the right mix and balance of roles. For example, Bryson and Warner Smith's work showed that for middle-aged women with children at home, a 25–34 hour working week rather than full-time work was associated with the best physical and mental health (Bryson & Warner-Smith, 1998).

Such data reinforce the importance of including flexible work conditions in any workplace strategy aimed at improving women's mental and physical health. 'Family-friendly' and 'work-life balance' policies that are effective in increasing women's capacity to choose a comfortable mix of roles are likely to improve the health of many working women. They also fit well within a social model of health. Such policies will be even more empowering if they are based on the belief that issues such as childcare, or caring for ageing parents are not simply women's issues, but are the responsibility of whole communities.

A social model of health also highlights other fundamental determinants of health such as discrimination and cultural factors. These are thought to account, for example, for the marked decline in mental health experienced by women from a non-English speaking background (NESB) on migration to Australia, especially through experiences of isolation and marginalisation (Alcorso & Schofield, 1993). These women also experience higher rates of employment-related injuries and accidents than their English-speaking counterparts. The concentration of NESB women in dangerous occupations and industries, their lack of fluency in English and difficulty in obtaining information about potentially dangerous products are all thought to contribute to their susceptibility to work-related illness and injury (Alcorso & Schofield, 1993).

Level of control over workload and how connected one feels to fellow employees are other important social influences on health relevant to workplace health promotion. Increasing women's participation in decision-making processes and job-design, or devoting work time to team-building activities can all therefore be seen as an integral part of a health initiative.

A social model of health does not diminish the importance of medicine, but enhances its effectiveness. Rather than simply recommend women have mammograms, a social model of health asks how can a working woman actually make time for the appointment and feel comfortable enough with the health practitioner to go through with the procedure.

What do we already know about working women's health concerns?

National statistics tell us the top three killers of women in Australia are malignant cancers, heart disease and stroke (ABS, 2000). In a Victorian 'burden of disease' study, breast cancer, depression, osteoarthritis and heart disease are the conditions most responsible for loss of quality of life for women aged 34–65 (Vos & Begg, 2000). However, ask working women what they are concerned about and there is little talk of cancer or heart attacks. Instead, it is the day-to-day battle with exhaustion that emerges as one of the most common themes from research into women's health.

Consistent with national studies, a survey of 120 professional women in Victoria conducted by *Corporeal~workplace wellbeing* in 2001 (O'Connor, *unpubl),* found stress was the most commonly cited health concern. When asked which health-related topics these women wanted more information about, tiredness and stress came up as the top two. Making time for self-care also rated highly. Mental health, it seems, is high on working women's personal health agenda.

Discipline and a healthy lifestyle are often promoted as the cure-all for overcoming stress and tiredness. Janet Joss, senior program manager of women's health, Royal Women's Hospital, takes a different approach (Joss, 2002, *pers. comm*). Rather than trotting out the well-known list of healthy behaviours we 'should' be exhibiting, she focuses instead on encouraging women to feel OK about saying 'No' more often to the demands of others. She uses the 'burnt chop syndrome' as an analogy that many women can relate to:

> *There are five chops on the barbecue, one of them gets burned so mum serves all the good ones to everyone else and eats the burnt one herself. That's how women can be with their health – letting others' health and wellbeing needs take precedence over their own (says Janet). But unless women are looking after themselves, they cannot work well and care effectively for others, at least not for very long.*

State-based women's health services are most commonly contacted for information about sexual and reproductive issues such as pregnancy, menopause, contraception and menstruation. Chris Ferlazzo, health information officer for Women's Health Victoria (a statewide women's health information service) says many of the conversations she has with women about their health concerns lead to workplace issues (Ferlazzo, 2002, *pers. comm.*). She gives the example of a woman going through menopause: sitting in the boardroom experiencing hot flushes, going bright red, and feeling so hot she can't concentrate; she thinks everyone is watching her and ends up feeling stressed about showing any 'weakness' that might indicate she's not up to the job. 'Essentially these women want help dealing with their health issues so they can work well, and not be considered less than', Chris says. Providing women with access to quality women's health practitioners and services can help. Challenging the unspoken workplace culture that might say it is 'weak' to need time off, get emotional or be changeable and 'unpredictable' is just as important.

In addition to tiredness and sexual health, each industry has its specific health risks, which occupational health and safety managers well know. For example, occupational overuse syndrome, stress and back injuries are common in female dominated industries such as clerical, retail, personnel services and in textile, clothing and footwear manufacture.

Solving health issues over lunch

Working Women's Health is a not-for-profit organisation offering lunchtime group sessions for women of non-English speaking background in the textile, clothing and footwear sector. Overuse syndrome, stress and health problems relating to noise and dust are common in this sector. Six half-hour sessions are facilitated around the issues of sexual, reproductive health, occupational, and mental health issues. Space is created for both giving and sharing of information. The manager of a knitwear company recently enabled her female staff to participate in the six-week program. She says it gave the women a chance to ask questions they are hesitant to ask in everyday life. 'Women have a right to know about their health, but many of these women work all day, then return to their own culture at night, so are not able to access information that is useful to them', she says. While the benefits are not immediately apparent, she believes the more educated her workers are, the better it is for everyone. According to this manager: 'It also made the girls happier, gave them something to look forward to and was a new experience'.

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How working women like their health care (or, what women want)

Around two thirds of the women surveyed by *Corporeal* (O'Connor, *unpubl*) said they wanted their workplace to offer a greater level of health assistance specific to their needs. They also believed improved health services would enhance their perception of management as they would feel more valued. When asked how they would like their health care delivered, there was a fairly even spread between those who thought changes in human resource (HR) policy were more important, and those who most valued provision of on-site health services. If offered on-site health seminars, the majority (80%) said it was important to have a female facilitator and most (70%) wanted a blend of traditional and alternative health approaches.

Women's Health Victoria (Ferlazzo, 2002, *pers. comm.*) reports when women are asked what they want, access to quality health information (including alternatives to drugs and surgery) rates highly, as this allows women to make informed decisions for themselves. Chris Ferlazzo of Women's Health Victoria also points out that what women want most is to be listened to, to be heard and understood, to have their experiences validated, and not dismissed:

> *One of the most common things I hear from women when talking about their health problems is, 'If only they [my husband, boss or co-workers] understood what I was going through' (says Chris).*

Workplace health promotion practitioners who draw upon this existing knowledge, as well as feedback from female staff, are likely to get a positive response. Given their existing interest in health and tendency to be more active in their own health care, working with women at work is an investment in health and healthy workplaces.

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For quality information on women's health

Women's Health Information Centre Ph: 03 9344 2007 (accepts reverse charge calls for interstate and rural calls) www.wellwomen.rwh.org.au (can email requests for information).

Women's Health Victoria Information Line 1800 133 321
www.whv.org.au

Women's Health Queensland Wide Ph: (07) 3839 9962
whcb@womhealth.org.au

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Getting answers to questions about drugs

Working Women's Health (WWH) was recently funded to conduct a drug and alcohol education program for women of non-English speaking background in the textile, clothing and footwear section. WWH began by asking the women what they wanted to know. 'No-one has ever asked me if I wanted to know', was such a strong response to the consultation phase, it became the title of the program report. The manager of WWH says during the program, many women reported dealing with stress over prolonged periods of time (often related to job insecurity) which for some, proceeded to anxiety and depression. Many were taking tranquillisers, pain-killers or anti-depressants without knowing what they were or how long they should be taken for. After participating in the program, the women were most appreciative, citing several benefits, including:

- having access to health information they would otherwise have missed
- a forum where they could discuss topics openly and share concerns
- relief from worries they had been pre-occupied with, and
- increased self-awareness and better coping skills.

Pregnancy at work

A new program for helping women manage pregnancy at work is being piloted by Westpac Bank of Melbourne, Victoria. The program educates staff members and managers about injury prevention, lifestyle and workstyle for a safe pregnancy, as well as HR issues such as leave entitlements and return to work processes. Women are targeted early in their pregnancy, and incidence of injury in pregnancy and return to work rates after giving birth are monitored. The program has been embraced by management, fitting well with Westpac's policy of being a 'family friendly' employer, willing to provide extra care for its workers. A breast feeding policy, six weeks paid parental leave, work-based childcare facilities, discounted rates with certain health care funds and the ability to use sick leave for other reasons are among the range of policies used by Westpac to look after its female employees. The diversity manager for Westpac says since workers have a range of needs, a range of solutions is needed for employee health and wellbeing. Another senior manager at Wesptac, recently returned from six months maternity leave, says: 'The flexibility and consideration shown during my pregnancy, my leave and on return to work made me feel even more valued by the company'. Before going on leave, she received permission to take time off for doctors' appointments, the paid maternity leave assisted her financial situation, and the offer to come back part-time, with a start time of 10 am, helped her ease back into work without having to get up early after night feeding.

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Singing to save your sanity

Evidence is emerging to support the idea of large organisations conducting arts and health programs in the workplace. Collaboration and cooperation between government organisations and departments in the arts, health and education arenas is needed to elevate the pivotal role the arts can play in caring for not only sick, aged and infirm people, but also workers in a range of industries. *Corporeal ~ workplace wellbeing* organised a trial singing group as part of their health and wellbeing program - linking the arts, their business and other small business tenants of Business Matrix, Melbourne. Singing groups are a great way to unite a group of people, provide stimulation to the mind and body, tap emotions, as well as provide a form of relaxation and social interaction. Corporeal's singing group is run by a community choir conductor for one hour per week over approximately six weeks. Numbers attending each week range from 8-15. Evaluation of the group generated the following comments:

> *It has been really good for meeting other people around the whole building*
>
> *I do tend to feel more relaxed after it*
>
> *It gets you right out of work…the stress of the work environment…and into another space, which is very useful when in the middle of a working day*
>
> *I generally go into the session quite tense…by the end of the session I am really relaxed and my energy levels have gone right up*
>
> *It's really nice to be able to hear the harmonies that can be created by a group of disparate voices…that have no particular relationship with one another*

5 Working for Ages: active strategies for a productive workforce project

Bernadette Fallon

This paper discusses discrimination against people over the age of 45 in employment and a new project aimed at tackling discrimination. 'Working for Ages' is a joint project between the Equal Opportunity Commission Victoria, the Department of Human Services under its positive ageing banner, and VicHealth as part of its *Mental Health Promotion Plan*.

Work and the ageing population

The second half of the 20th century was characterised by populations in the industrialised world living longer, healthier lives. Alongside that rise in life expectancies there has been a marked decrease in fertility rates. Together, these two factors have resulted in a remarkable ageing of the population. There are larger numbers of healthy active people in older age groups than at any time before (ABS, 1999a).

In 2001, 33.5% of the population was aged over 45 years. That figure will rise to 43.6% by 2021. By 2051 the number of people aged over 65 will have tripled to between 6.4 and 6.8 million, and the population aged over 85 is expected to rise to 1.3 million (ABS, 2000). According to Access Economics, it is estimated that two thirds of those to ever turn 65 are alive today (Access Economics, 2001).

Population ageing is of course mirrored in the workforce. For example, workers over 45 are the fastest growing sector of the workforce and by 2005, it is expected that 35% of the workforce will be in this age group. Those born in the peak year of the baby-boomer generation, 1945, will turn 55 this year (ABS, 1998; CDH&AC, 1999).

Australia's ageing population – a snapshot

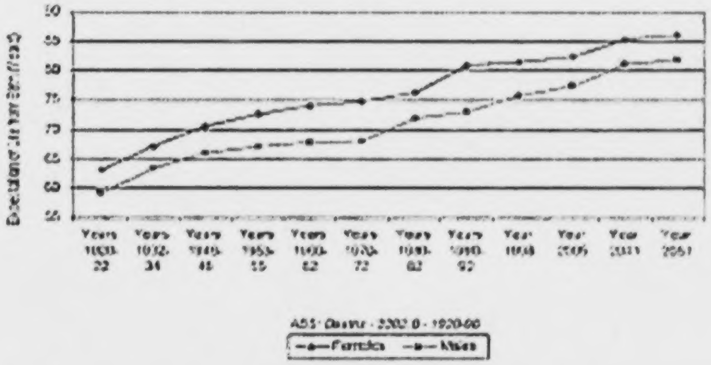
(Fact sheet EOC Victoria)

- Proportion of total population aged over 45 from the year 2000 to 2021.

Year 2000	33.50%	Year 2001	35.40%
Year 2006	38.00%	Year 2011	40.10%
Year 2021	43.60%		

- The OECD states that 'growth in material living standards in Australia will halve by 2010' if the proportion of the population who are working and productivity growth remain the same.

Table 5.1 Expectation of Life from Birth 1920 to 2051



- Workers over 45 are the fastest growing sector of the workforce.
- Age was the single most significant reason for lack of re-employment of two thirds of unemployed persons aged 55 and over (ABS Cat No. 6245).
- Those born in the peak year of the baby boomer generation (1947) reach the age of 55 in 2002. Companies with mandatory retirement ages of between 55 and 60 may begin to have trouble replacing staff in the next few years.
- Projections suggest that by 2005, 35% of the workforce will be aged over 45.
- Currently the working age population is increasing by 170,000 per annum. Between 2020-2030 it will increase by only 12,500 per year.
- Workers over 45 are more likely to be discouraged in their jobseeking than under 45 year-olds because age is seen as a negative by many Australian employers.
- Skill shortages are likely to result if Australian business does not utilise the skills and talents of workers over 45.

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Workforce age-related discrimination

Despite the rise in the proportion of the workforce aged over 45 years, people in this age group report high levels of age-related discrimination. Research by the Equal Opportunity Commissions in Victoria, South Australia and Western Australia with the Australian Employers Convention shows age discrimination against mature-aged workers is widespread and largely hidden. The report, *Age limits: age-related discrimination in employment affecting workers over 45*, details how age discrimination affects every stage of employment for mature-aged workers. These workers face difficulties in finding and keeping work and accessing training and promotion opportunities, and are often the first people approached for retrenchment and redundancy (EOC, 2001).

Mature-aged workers find it harder to gain work when they are retrenched. Australian Bureau of Statistics figures from 1998 showed the average period of unemployment for men over 55 years was 104 weeks. This is vastly more than the male average at the time of 70 weeks. For women over 55, the average was 107 weeks, compared with the female average of 52 weeks (ABS, 1998).

Comments taken from focus groups conducted for the Age Limits report give voice to the experience of age discrimination. One worker advised by a recruitment agency to leave his age off job applications said, 'The agency told me that without the age I could still be shaped into a saleable package'. In interviews, it is a common experience for workers to feel they are negatively judged by their age. One woman reported being offered a job by the HR manager, only to have this happen:

> The general manager came in and winced and wouldn't look at me. They never rang me back. I rang and they gave an excuse that they were going to get someone more experienced (EOC, 2001).

These stories are typical of those told by mature-aged people about their search for work. Little wonder that mature-aged workers are more likely to be discouraged in their job search than those under 45. This level of discouragement is so widespread that ABS workforce participation figures suggest that in some older age groups, for every person voluntarily retired there is another who would rather work. Overall, in the 45–64 age group, one in every three jobseekers is thought to have given up their search because of discouragement. For every woman who is actively looking for work in the 55–59 year group there is thought to be another who is discouraged, and the same one-to-one ratio applies for men in the 60–65 age group (ABS, 1999b).

In conversation, mature-aged workers often express a lot of anger and frustration about their situation. Judgements based on age and stereotypes about incapacity linked with age are impossible for mature-aged people to combat because the judgements are not being made about objective skills or talents or capacities for work. Instead they are based on a set of assumptions about which the individual has no control.

Such assumptions reinforce discrimination based on age and can have negative consequences on people's mental health and wellbeing, including social isolation, decreased self-esteem, stress and depression (VicHealth, 1999, p34).

Things you may not know about mature-age workers

(Fact sheet EOC Victoria)

Negative attitudes and stereotypes about mature-age workers abound in workplaces across the country. Like most stereotypes, when examined closely, they collapse. This fact sheet examines some of the myths about the abilities and capacities of workers over 45 and looks at the cost in human resource terms of not employing this group of people.

- An Australian survey showed mature workers retain information better than their younger colleagues and also have good learning capacity. The Seattle Longitudinal Study directed by Warner Schaie (1998) tracked 18,000 people over a 36-year period (from 1956). It subjected those people to a battery of tests examining five abilities: verbal ability, spatial reasoning, inductive reasoning, numeric ability and perceptual speed.

  Peak ages for performance are occurring in the 50s for inductive reasoning and spatial orientation and in the 60s for verbal ability and verbal memory. There is overlap between the performance of young and old workers until the 80s are reached. Broad individual differences exist in the speediness of behaviour (Schaie, 1998, p351).

- Evidence suggests productivity doesn't decline with age. Some abilities, such as intellectual skills, are said to rise with age and comparisons between active 65 year-olds and active 25 year-olds in memory and learning skills are similar.

  Studies have also indicated that as workers become older, their job performance increases.

  A 1986 study (Waldman & Alvolio) found mature workers' 'output level, accuracy and steadiness of work output' was strongly related to their increase in age. The over 55 age group has the fastest uptake of internet usage.

- Workers between 55 and 69 stay in a job longer than their younger colleagues. In any year, 25% of the 20–24 age group change jobs. In the same period, 5%

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of the 55–69 age group changes jobs. Therefore a younger worker is five times more likely to change jobs in a given year than their counterparts over 55.

Attendance records are actually better for the mature-age group. A World Health Organization study showed those over 45 took fewer sick days. 1998 ABS data showed of those employees absent on sick leave, only 14% were in the 55+ age group.

- It is true that on average, weekly earnings for the 55–59 age group are higher than for the 25–34 group ($835 compared to $765). These costs need to be compared to productivity and costs of recruitment, hiring and training. Research by the Australian Employers' Convention (2001) states the mature-age worker will cost an employer less than those under 44.

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About the Working for Ages project

As part of its Mental Health Promotion Strategy, VicHealth is a partner in funding the Working for Ages project. The VicHealth *Mental Health Promotion Plan* identifies older men and women as one of the target groups, and sees participation in the workforce as a key determinant of older people's mental health. Discrimination against mature-aged people can create health inequalities by excluding a sector of the population from participating independently in economic activity – a significant determinant of health.

The Working for Ages project is a Government response to the level of discrimination faced by mature-aged workers. It is a partnership project between VicHealth, Equal Opportunity Commission Victoria and the Department of Human Services as part of its positive ageing strategy.

Equal Opportunity Commission Victoria is an independent body set up to eliminate unlawful discrimination and promote equal opportunity in Victoria by providing a fair, impartial, confidential and low-cost complaint resolution service, and by informing and educating Victorians about their rights and responsibilities under equal opportunity laws. Placing the project at the Commission has given it a unique strength in terms of playing a role in educating the community and raising awareness of the positive benefits of mature-aged workers.

The project is designed to increase awareness of issues surrounding workforce ageing and to dispel some of the myths about mature-aged workers, employment and their capacity to learn and work. It also highlights the positives that can flow to employers, workers and the community through the continued employment of workers over 45.

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The project has been working to:

- develop educational and information products to raise awareness and improve adherence to Equal Opportunity Legislation
- challenge ageist stereotypes
- explore the capacities of workers over 45 and promote their positive contribution in employment
- study the demographic and economic impacts of an ageing population and its likely impact on business
- develop and disseminate international and Australian examples of business best practice
- host regional forums in the east and west of Melbourne.

A range of organisations from the government and community sectors along with employers, recruitment organisations, unions and peak bodies has attended the regional forums. Each region has developed priority areas and topics for the project to work around.

Examples of projects viewed as priorities include: educating employers in the benefits of both recruiting and maintaining mature-aged workers; rethinking work and its place over the lifecourse of individuals to promote the idea of career planning in the middle years; and examining flexible work options and their influence on retirement intentions. Other projects being developed include developing training models targeted to the learning styles of mature-aged workers. A series of fact sheets has been developed and examples are included throughout this article. All fact sheets are reprinted with permission from Equal Opportunity Commission Victoria. I will leave you to ponder the following fact sheet on age balance programs.

Age balance programs

(Fact sheet EOC Victoria: reprinted with their permission)

B & Q, Hardware retailer

Anticipating the demographic effects of an ageing population in the 1980s, B & Q decided to pilot a scheme to staff an entire store with employees over the age of 50. The pilot program had the following outcomes:

- 39% reduction in absenteeism
- profitability exceeded management targets for the start-up period and was 18% higher than average profitability of five B & Q comparison stores

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- employee turnover was six times lower than the average of the five comparison stores
- marked reduction in shrinkage as customers were being carefully watched.

B & Q now prefer to staff all their stores with an age-balanced workforce. They have also opened their management-training scheme to workers of all ages, where previously it had been confined to those under 25. They have found these strategies reduce their staff turnover and recruitment and training costs.

ITW Buildex Moorabbin Victoria

To utilise product knowledge and relevant skills, ITW Buildex maintains an age-balanced workforce. ITW employs sales staff into their 60s and 70s to ensure they keep staff with good product knowledge. When sales staff no longer want to be out travelling and climbing on customers' roofs, they can move to the call centre help desk service, where their skills can still be utilised.

Because ITW have an age-balance policy, they also work with their employees to develop flexible work options prior to retirement. Workers can phase in working part-time over a number of years, as they make decisions about what suits their stage of life. Some staff have continued to work into their 70s. This flexibility has made succession planning less costly for ITW, as they have significant lead times to develop strategies for replacing key employees.

Nationwide Building Society, UK

To decrease staff turnover, Nationwide brought in a system of recruiting based solely on skills and abilities. Nationwide now interview all potential recruits over the telephone to eliminate the possibility of assumptions based on appearance influencing employment. While this hasn't replaced the need for face-to-face interviews, it has resulted in a larger number of people in their 50s being employed, who traditionally would have been rejected at short listing stage.

Nationwide has found these changes reduce their staff turnover and recruitment costs and they now have a workforce that better fits their customer profile.

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LEISURE TIME FOR SALE

6 Youth employment, psychosocial health and the importance of person-environment fit: a case study of two Scottish rural towns

Stephen Pavis, Stephen Platt and Gill Hubbard

It has been argued that during youth, paid employment fulfils a number of functions: to provide material resources to undertake childhood to adulthood transitions; contribute to identity formation; provide structure to the day; and promote social inclusion and integration. However, young people are not a homogeneous group and do not all participate in the same labour market, either geographically or in terms of skill levels. In this paper we report on the experiences of young people from two small rural Scottish towns. The study locations were chosen to contrast in terms of their proximity to urban conurbations and available types of employment. One area, Callander, has been heavily affected by tourism and incoming urban working commuters, while the other area, Duns, has remained more traditionally rural. Data were gathered using qualitative interviews (n=60) and a structured postal questionnaire (n=187). Secondary data were analysed to provide contextual knowledge that would aid the interpretation of interview and survey data.

Findings show strong similarities in the experiences of respondents from the two study areas. The majority of available employment was repetitive, and involved poor working conditions and limited opportunity for skill development or promotion. Some respondents reported valuing these types of work for short periods, particularly during the initial post-school period, while studying or in response to a need to earn money quickly. However, most respondents recognised that in the longer term such work was detrimental to their quality of life and sense of wellbeing. These data suggest that it is an oversimplification to treat all employment as equivalent. They raise important questions regarding whether low quality work does in fact fulfil the positive functions often claimed for employment.

Introduction

In Europe, the last 15 years have seen important changes to the structure of labour markets. Key forces for change have included economic recession, growing international competition, the decline of traditional manufacturing, the rise of new technology and service sector employment, and the growth of the short-term contracts and part-time working (De Grip, Hoevenberg, and Willems 1997). However, these structural changes have impacted variously in different countries and on different groups of workers. For example, labour market participation rates among older workers have fallen generally but the steepest declines have been in Finland, France, the Netherlands and the UK. Overall, working hours have reduced. However, the UK and Ireland remain exceptions. The former now has the highest average weekly working hours in the European Union. Participation rates among women have increased, particularly in the 25–49 age group, and in Scandinavia the gap between male and female participation has almost disappeared.

Young people are arguably the group of workers to experience the most significant change, in terms of labour market participation rates and types of employment. For Hammarstrom (1994), youth unemployment is now 'one of the greatest social problems facing the Western world'. Young people's labour market locations and experiences are significant for a number of reasons. First, employment provides young people with the material resources to undertake some key transitions in their movement from childhood dependence to adult independence, for example from parental home to independent household and/or from family of origin to family of destination. Second, employment remains key to identity formation and provides many people, young and old alike, with a sense of purpose and a structure to the day(Jahoda 1979; Jahoda 1988). Third, youth has traditionally been a time when individuals acquire the work skills that largely structure their future employment prospects. Finally, it is often argued that labour market participation also promotes social cohesion and integration. Indeed, labour market participation, either through employment or training, lies at the heart of New Labour's social inclusion agenda (Levitas, 1998).

At the same time, 'youth' cannot be treated as a homogeneous category. Young people's experiences are shaped by many factors, including international, national and regional social policies, their family's socio-economic status, education and training experience, gender and ethnicity. It is also important to recognise most young people attempt to participate in labour markets located around the geographical areas where they grow up. This is particularly true for those who leave education at a young age and lack the experience, social skills and material resources required to relocate in search of work.

Since the beginning of the 1980s there have been increasing numbers of research papers concerned with the health consequences of youth unemployment. These have been largely quantitative in design and have shown a consistent relationship between youth unemployment and minor psychological disorders (Hammarstrom 1994; Warr 1987). However, there is a dearth of literature looking at the quality of available work and possible relationships between youth employment experiences and psychosocial health. Few studies have taken a holistic view of young people's lives and examined the ways in which they construct their lived experiences by making choices within concrete social situations. Drawing primarily on qualitative data, this paper examines young people's experiences in two rural towns in Scotland and examines how they secured employment, the implications of different types of labour market positions for social inclusion and integration, and young people's perceptions of the relationship between employment situation and psychosocial health and wellbeing.

Study design

The data on which this paper is based are part of a larger study of social inclusion and exclusion in rural Scotland. This study examined the experiences of young people (18–25 years) growing up, entering the labour market and living in and around two rural Scottish towns (Pavis, Platt, and Hubbard 2000). The study aimed to compare the experiences of social exclusion and insertion of young men and women in two contrasting rural areas, and to examine how young people of different genders use personal and social/community resources to enhance social inclusion and (re)insertion.

Both of the study towns had populations of about 2,500. The first, Callander, lies at the gateway to the highlands and has been heavily affected by tourism. It has good road links to two of Scotland's cities Glasgow (about 40 minutes by car) and Stirling (about 25 minutes by car). These factors have led to a growth in employment in tourism and some in-migration by people who work in the 'nearby' cities (that is, commuters), primarily in finance, business and public service sectors (see Table 6.1). The second area, Duns, in the Scottish Borders region, has remained more traditionally rural and because of a poorer transport infrastructure (in terms of roads and lack of rail-link), residents tend not to commute to the nearest city (Edinburgh, one hour and 15 minutes by car). In Duns, employment is primarily in light manufacturing and food processing. However, in the wider Borders region the main sources of employment are textiles and, until recently, electronics.

Table 6.1 Numbers employed in each sector in 1995

Employment sector	**Borders**	**Stirling**
Agriculture, forestry & fishing	442 (1)	275 (0.8)
Manufacturing, food, drink & tobacco	778 (2)	0
Manufacturing, textiles products, leather	5,052 (15)	0
Manufacturing, pulp, paper products, printing	459 (1)	0
Manufacturing, timber, rubber, plastic	938 (3)	0
Construction	2,220 (6)	1,621 (5)
Hotels and catering	1,991 (6)	3,506 (10)
Financial and business	2,466 (7)	4,104 (12)
Public services, administration & defence	4,229 (12)	6,888 (21)
Total (includes those employed in sectors not included above)	34,834	33,501

Source: 1995 Census of Employment. Percentages in parenthesis, based on a total N of Borders 34,834 and Stirlingshire 33,501

Table 6.2 Household tenure and amenities 1991

Description	**Duns**	**Callander**
Total households	1044	1019
No central heating	159 (15%)	123 (12%)
No car	358 (34%)	295 (29%)
Owner-occupied	502 (48%)	694 (68%)
Rented privately	44 (4%)	12 (1%)
Rented with a job or business	492 (47%)	51 (5%)
Rented from housing association, local authority, new town or Scottish homes	20 (2%)	256 (25%)
Total renting	548 (52%)	327 (32%)

Source: 1991 Census General Register Office, Scotland

The town of Callander is slightly more affluent than Duns. For example, Callander contains more owner-occupied housing, more homes with central heating and has higher levels of car ownership (Table 6.2).

Data collection

The study involved the collection and analysis of three types of data: community resources audits (CRAs), semi-structured interviews, and outcomes of a structured postal instrument.

Community resource audits provided information that could be used to facilitate contextualised understandings of the interview and questionnaire data. The CRAs relied primarily on pre-existing statistical data, based on the 1991 census, and on information collected by regional councils, education departments, health boards and various housing agencies. A small number of supplementary qualitative interviews were also conducted with key personnel (that is, school headmasters, community education workers and the police) working with local young people.

Qualitative interviews were conducted with 30 young people (aged 18–25 years) in each of the two study areas (n=60). The samples were stratified so as to achieve broadly equal numbers of males and females, and an approximate two-thirds to one-third split between town dwellers and those living in more outlying areas. Individuals were randomly selected from sampling frames constructed from general practitioners' registration lists and old school registers, and then invited, in writing, to take part in the study. Not all the respondents were current full-time residents in the research areas. Some were students studying away from 'home' and others were young people who had recently moved for employment reasons. However, all respondents had close enough links to receive the invitation to take part in the study and all had enough knowledge and experience to make valuable contributions.

The interviews took place in the young people's homes and lasted between 40 and 90 minutes, depending on the salience of the issues to the respondent and the level of rapport with the interviewer. The interviews were semi-structured and sought to gather information in five key life domains: family, housing, education, employment, and leisure and community. For each of these domains respondents were asked, using various verbal prompts, to recount their experiences from early childhood through to the present day. The interviewer facilitated and encouraged respondents to tell their life story and the interviews produced rich and detailed biographical information. Some of these data were recalled 'facts', for example, how many jobs, homes, relationships, educational qualifications the respondent had had, or their level of income, housing costs, etc. Other data were at the level of feelings, emotions and perceptions.

A structured instrument was designed, piloted and subsequently administered by post to all of the young people in the sampling frames, including those who had taken part in the qualitative interviews (Duns n=245; Callander n=253). One follow-up reminder letter was sent, resulting in a response rate of 41% in Duns and 34% in Callander (overall 38%). The questionnaire gathered demographic information and contained sections on housing, education, income, employment, family and health. In addition, the instrument contained questions designed to measure key attitudes and values often cited as being associated with social exclusion – namely, ambition, self-efficacy and dependency. Wherever possible, pre-existing validated questions were used so as to aid ease of comparison with other data sets. The instrument contained questions drawn from the British Social Attitudes Survey (Bryson 1997) and Scottish Health Survey (The Scottish Office (SO) 1997).

Data management and analysis

The qualitative interviews were audiotape recorded, transcribed verbatim and entered into the qualitative data management package NUD*ist. Data were initially coded under nine broad themes: housing, health, work, family, social support, education, income, leisure and social exclusion. Within these domains further sub-themes were developed inductively. That is, we started from the data and what respondents had told us (in their own terms) and sought to identify recurrent ideas, experiences and perspectives, while also paying attention to the occurrence of divergence and difference (Lofland and Lofland 1995). When interview extracts are used within this paper, in order to aid respondent anonymity, we do not disclose whether the respondent came from Duns or Callander, although we do indicate the sex of respondents. The quantitative data were analysed using descriptive statistical techniques.

Findings

In this paper we focus primarily on the qualitative interview data. However, data analysis and interpretation were reciprocally informed by our complementary data sets (that is, the CRAs and structured instrument). In spite of the two study towns being chosen to contrast along certain dimensions, including transport infrastructure, dominant employment sectors and proximity to urban areas, the young people's experiences were similar in both areas. For this reason our discussion of three inter-related themes – the relationships between perceptions of locality and lifecourse stage, factors leading to out-migration, and the employment experiences of those who stayed – draws on data from both study locations. Respondents' perceptions of the factors affecting psychosocial health are integrated within these themes. Where differences in experiences between groups of young people were found, these are highlighted and discussed.

The relationships between perceptions of locality and lifecourse stage

Respondents in both areas commonly couched their views about locality and community in terms of how these met their needs at a particular point in their lives. When looking back to their childhood, young people tended to speak fondly about their areas. They pointed to the natural beauty of the physical environments and talked in terms of them being generally safe areas. They also reported feelings of being free and allowed to roam without fear. Often they contrasted their experiences of rural living with perceptions of city life and talked about the ways that children in cities are vulnerable to being attacked or accosted by people whom they do not know. However, these views of city life were commonly at the level of anecdote and stereotype, and based on very little, if any, direct personal experience:

Respondent:	*...it's safe, it's not like Edinburgh where it's maybe dangerous for young kids to go out and about.*
Interviewer:	*What do you think makes it dangerous in the city?*
Respondent:	*Em, it's busy and there's traffic, there's people danger (male).*

Respondents also talked about their communities being tight-knit and an important source of support during difficult times. Such 'support' did not always entail direct instrumental action and could sometimes involve the emotional security of knowing people were aware of difficulties and caring. In the following extract, a respondent recounts his experiences when his mother died:

Respondent:	*When my mother died...there was some people...I knew, just like to see, not to speak to, that came up like to speak to me which was quite good.*
Interviewer:	*So you found that quite important?*
Respondent:	*Yes, there was a lot of people, you know, just spoke to me, I'd just seen in passing and that, which was quite good (male).*

When respondents talked about their perceptions of their local communities in relation to their teenage years, however, their accounts were often noticeably different. In fact, some of the features that were cited as positive during childhood were now recast as being problematic. For example, the closeness of the community and the fact that everyone knew everyone else, factors which contributed to feelings of safety during childhood, were now portrayed as contributing to feelings of 'claustrophobia' and 'social control'. Some respondents expressed a wish for 'adventure' and to 'experiment' but noted opportunities to do so were not merely lacking but actively curtailed. Our data show such social control was not simply something imposed by adults upon adolescents, but also that there were often tensions between various groups of young people, particularly students returning from college and those who had not attended higher education:

> *... all the other people are so small-minded. Like, cause I used to have like long hair ...and wear flares (bell-bottom trousers) and that, and they always thought I was crazy or something. I mean, I've still got the flares but I got my hair cut, just for myself not for anyone else. It's quite amusing* (male).

In the interview extract below, a young woman who had moved into a rural area when her husband began working there, points to the ways that even during adulthood, the closeness of the community could be simultaneously both positive and negative:

> *I did find it uncomfortable because for the first few weeks or so, I went out for a pint of milk or something. I felt everyone was looking at me, sort of knowing who I was... it sometimes does still annoy me the way that happens with people. But I had a friend down from Edinburgh yesterday and we were walking along the street and there were people saying 'hello' to me ... and plus when we moved in here ... there's been no end of people offering help and I find that really nice* (female).

Similarly, the natural beauty and isolation which, during childhood, were seen by young people as promoting and allowing childhood adventure, were often portrayed during adolescence as adding to boredom and placing severe limits upon their social lives. For those young people living in the more outlying areas, a visit to the local pub could entail a very long walk home.

At the same time, even respondents who found it difficult living in a tight-knit community during adolescence, did not automatically rule out living there when they themselves became parents. Thus, people's perceptions of their local environment and community differed according to their lifecourse stage. Respondents recognised and acknowledged they had different needs at various times in their lives and when evaluating their local environment and community, they engaged in a process of weighing up the extent to which their perceived needs were being met at a particular point in time.

Factors leading to out-migration

The Scottish Young People's Survey found by the age of 25 two-thirds of young people have left the Borders region (Jones and Jamieson 1997). Comparable statistics for Stirlingshire are not available. However, the young people's accounts gathered during this study suggest the situation in Callander may be similar to that in Duns. Borders region and Stirlingshire have good networks of further education colleges. Stirlingshire also has a university but it is located a considerable distance from Callander and daily commuting is impractical without the use of a car. In the following interview extract, a young woman describes the problems she encountered when trying to work in Stirling (the university is a further seven kilometres outside of town):

> *I spoke to the head of personnel for [large retailer] who was doing the interviewing, em, I fibbed ... 'Oh yes, there's buses ... I'll get there for seven o'clock in the morning', you know, so I just answered 'Yes' to every question, absolutely desperate for this job. They gave me the job, em ... there was no buses ... I didn't know anybody in the area that was heading that way, so I sort of said to the Head of the Personnel Department 'Look, I'm terribly sorry, but there isn't any buses, I don't know if I can get here' ... She says 'Right okay that's fine, you can just leave' ... And my Mum phoned an' said, 'Listen, I'm gonna run her to her work'. My Mum got up at six o'clock in the morning to run me all the way to Stirling from (place name) for two hours work an' she'd drive all the way back an' I'd have to make my own way back, which meant hanging about until the school bus which would be what, three o'clock in the afternoon* (female).

Borders region does not have a university, the nearest being in Edinburgh, some 70 km away. In both areas the more academically-able young people were therefore forced, or at least enticed, to leave the area. Within both communities it had become culturally expected that the more able young people would move away and local people expressed the view that those who did not leave were lacking in ability, motivation and/or ambition. In the interview extract below, a young man who was studying in Edinburgh describes the emerging social distance between himself and some of the young people he had known at school. He articulates his belief that those who had stayed in the community were placing self-imposed limits upon their opportunities:

> *...a few folk moved away but they just went back... straightaway. In some ways, I found it kind of depressing... I feel sorry for them in a way, that they're not seeing what there is in the world. And they're just going to be stuck there, but that's their choice I suppose. ...if I go out with a friend, it's weird because a lot of the people you recognise, but they seem scared to talk to folk that, you know, they talked to four years ago, and what's changed now? You know, they're just still there and I'm here (Edinburgh)...* (male).

The employment experiences of those who stayed

Young people who did not leave the research areas tended to be the lower academic achievers. As Table 6.3 shows, the number of unemployed young people who were claiming benefit was higher in Callander than in Duns, in spite of Callander being a slightly more affluent area. Employment in Callander was also affected to a greater extent by seasonality, with unemployment tending to be higher during the winter months than was the case in Duns.

Table 6.3 18–24 year-olds unemployed and claiming benefit in 1998

	Duns	Callander
January	11	23
April	9	19
July	5	16
October	4	15
December	6	34

Source: Employment Services personal communication

In both study areas the labour markets suffered from a lack of diversity. Most available work was repetitive manual labour offering little chance of career development or personal learning. Respondents living in Duns were largely employed in food processing, seasonal farm work and in care work (particularly the young women). In Callander, the main employment sectors were tourism (primarily hotel, bar and restaurant work) and forestry. Our questionnaire data show that, among the young people who were receiving wages, the average net monthly income was £536 (Euros 832) in Duns and £576 (Euros 894) in Callander. Respondents' accounts of day-to-day working life reveal it could often be very poor in quality. In the first interview extract below, a young man describes his employment in a local fish processing plant. In the second extract, a young woman describes her job in a knitwear factory:

> *Oh it's got a reputation alright... I mean the folk that they take on as charge-hands and that are... phff I've got no word to emphasise how bad they are, ... they've not got ...a clue on how to cooperate with their workers and that. I mean... it's all the f...ing and blinding words, 'You get f...ing on with that' ... I mean, if you're going to work in an environment like that, you'll not do the job properly. ...I mean with somebody speaking to you like a bloody animal, I mean, you think 'Oh phff, F off, if that's the way you're going to treat me'* (male).

> *Oh, it's just, if you can imagine a jumper, it's sewing these bits together. Sewing the arms on, all day, every day. ...Oh, it's just boredom, total boredom, and it was a factory full of women, so it was total boredom and bitchiness* (female).

In both study areas informal networks, such as family and friends, were found to be crucial to securing employment. Very few respondents obtained work through the more formal mechanisms of job centres or newspaper advertisements, as the following extract shows:

Interviewer: *So how did you get the forestry job?*

Respondent: *It was through one of the guys I play rugby with. It was him that said there was... 'cause I was still working at (the chicken factory) and as you'd imagine I got quite sick and fed up of that. He said to me, 'there's a job coming up, do you fancy it?' Well the money had something to do with it as well, you know, it was better money than what I was getting...I get £200 (Euros 310) a week. Which is not bad for round here* (male).

However, because of the importance of informal recruitment methods and high levels of social knowledge within the community, young people with bad reputations found it very difficult, if not impossible, to gain employment. 'Bad reputations' arose from a variety of different problems, ranging from mental health or learning difficulties through to drug use or other criminal activities. In the interview extract below, a young man who had committed several crimes (house breaking) during his early teens describes his predicament:

> *Half the time I feel like, just pack the bags and just leave. But you just can't do that, but what's interesting in my life now – nothing. I can't do anything, can't work, there's nothing, the only thing I can do is walk about, sleep, walk about, sleep, walk about... I like to do things but there's nothing round here... it's just four walls, Sky*

> *TV and that's it or walk about* (male).

In spite of the lack of diversity in employment, the often poor working conditions and associated low wages, at some points in their lives respondents still reported valuing the available employment. Students, for example, often worked during the summer to pay debts and/or to save money for a holiday. For other respondents, particularly those who were not yet thinking about setting up an independent household, these types of work provided money to buy a car, an essential possession in isolated areas, and funds for social lives.

The available employment seemed to become most problematic when there was a mismatch between respondents' perceived labour market needs and the available opportunities. Commonly these disparities occurred around lifecourse transition points, for example, when a respondent wished to set up an independent household, or when a child was expected, or when someone became frustrated by the recognition that this type of work was likely to be long-term rather than stop-gap. In the interview extract below, a respondent reports his perceptions of the effects of repetitive low-skilled employment on his health:

> *When I was working about my birthday last year. I was so depressed. It was like, it was horrible. ... I was going nowhere, no prospects. I just felt like shit. 'Cause I'd been feeling like crap for a few months for some reason, I don't know, I'd been to the doctor and he said there was nothing wrong with me, he'd taken my blood and everything. ... it was probably psychological* (male).

Our data also show that for some respondents it was the need to respond to changing life circumstances that led them to enter, or continue in, problematic employment situations. The interview extract below graphically illustrates the reality for some respondents' lives:

> *I would never have went for the job there, if it hadn't been for Morag coming along. Eh, I was kind of forced to .... I'll just persevere down there until something better comes of it. I've had opportunities for labouring jobs and that but I can't change jobs now, because I'm on a higher wage than I would get anywhere else at the moment. So until something outrageously well paid comes along, I'll be stuck down there... it's just the same thing over and over again, you know, it's just repetitive ... there's no skill* (male).

For respondents who had not attended higher education, pregnancy was a common trigger for the creation of independent households. Mostly the young people who formed households under these circumstances obtained accommodation in the private rented sector. Their low incomes excluded them from owner occupation, while state 'right to buy' housing policies had led to a shortage of Local Authority (social rented) housing stock. The private housing market worked in a similar way to the local labour market in that much accommodation was allocated through informal networks. As the following interview extract indicates, much of this accommodation was of low quality and located in isolated rural areas:

> *Well I pay £160 (Euros 248) rent a month which isn't that bad for the actual house so, it's quite good. It's coal fire so the house is quite cold, I mean we've got a storage heater at the top of the stairs but in the winter it's... in the winter it's really, really cold. The rain comes in through the windows and everything, it's terrible. But in the summer it's lovely, really nice. ...(later on) I've got an immersion for in the summer. But the tap drips up the stair so the immersion has to be on for hours and hours before... He (landlord) doesn't really bother much, so you have to be on at him the whole time to do something... he doesn't like spending money on the houses* (female).

Discussion

In the UK the last 20 years have seen a series of social and educational policies aimed at encouraging young people to continue into post-compulsory education or training and/or to facilitate their movement into the labour market. Concerns about the position of youth have been expressed by all the political parties, ranging from fears about Britain's declining labour skills and economic competitiveness to moral panics about the alleged growing underclass of dangerous and alienated youth. Labour market participation is still held as key to the promotion of social solidarity and what the current Labour administration terms an 'inclusive society'. Moreover, research has repeatedly shown employment status to be the key to self-identity and the promotion of physical and mental health.

Current British social inclusion policies are premised on a consensual model of society, wherein citizens share core values and ideals (Silver & Wilkinson, 1995; Social Exclusion Unit. 1995; Levitas, 1998). However, the findings from this study provide insight into the complexity that lies behind political notions such as creating 'strong communities' or an 'inclusive society'. These data highlight the ways in which the same social environment can be perceived variously by the same person at different points in their life. Even within one age group (18–25 years) we found differences in experience and division between various social groups, particularly those who had attended higher education and those who had not. At both emotional and practical levels, respondents did not speak generally about their community as either supportive and cohesive, or conversely, as controlling and divisive. Rather, respondents tended to mention the aspects of their environment and community that they valued (or otherwise) for a particular purpose or at a specific point in their lives. Thus, it was not uncommon for respondents to describe their community as controlling, whilst also recognising the community's strengths and/or advantages at other life stages or in other situations.

These findings are of interest when considering the impact of social experiences on wellbeing. For many years there has been debate about whether it is most appropriate to try to understand and ultimately intervene in the determinants of 'domain specific' (for example, relationships, income and employment, leisure) or 'global' wellbeing (Bradburn, 1969; Ryff, 1989; Pavis *et al.*, 1998). The findings from this study draw attention to the ways people experience life as a whole, while on occasion also encountering difficulties in particular life domains (employment, housing, family relationships, community integration). Similar social experiences or situations can be perceived to impact differently on wellbeing at various points in the lifecourse. To illustrate, rural isolation can be seen as enhancing wellbeing during childhood because of the freedom it affords, but also as constraining wellbeing during the teenage years because of its impact on access to public leisure facilities (for example, pubs, clubs, cinemas etc). Indeed, within our data, there were examples of respondents perceiving positive and negative impacts of the same social situation or context at the same point in time. Social cohesion, for example, could be seen as both constraining and a source of support and comfort. These findings highlight the ways theoretical concepts such as wellbeing and quality of life make sense only when they are grounded within specific cultural contexts and individual biographical experiences.

In relation to the question of whether our respondents were socially included, again our data highlight the complexity of lived experience. On the one hand, those respondents who had attended higher education could be seen as the most socially included. They had achieved within the education systems and were heading for professional-type employment with higher material rewards. However, in order to continue on this path they had to leave their family and community support structures. Within the study sample, several respondents reported not being emotionally or practically equipped for this early transition to independent living. These young people often dropped out of education and returned to the local community with considerable debt. On the other hand, respondents who had stayed in their community of origin, and were thereby close to their support networks, had lower educational qualifications and were often perceived by members of their community as being less able or as lacking in drive and ambition.

In relation to labour market participation, the young people from our two case study towns were in some ways fortunate. They grew up in areas with relatively low youth unemployment and wage levels slightly higher than the then recently introduced national minimum wage (£3.00 per hour [Euros 4.7]for 18–20 year-olds and £3.60 [Euros 5.5] for people over 21 years at the time of the study). However, our data raise important questions concerning whether the available jobs, often very repetitive, involving poor working conditions and limited opportunities for promotion, do in fact fulfil the positive functions often claimed for employment. Some young people found these jobs acceptable for short periods, particularly during the initial post-school period, or as a response to a need to earn money quickly. This work provided structure to young people's days, in the sense that it gave a reason to get up in the morning and somewhere to go (often for working days as long as 12 hours). However, this structure was not often perceived as something beneficial; rather it was viewed as a waste of time and as something to be endured. It was also true that the available employment provided the young people with social contacts but, again, these were not always considered to be pleasurable.

At the theoretical level, we suggest that when considering the likely impact of employment on mental health it is useful to consider both the 'intrinsic' nature of job tasks and the social context in which they are completed, while also paying close attention to the 'instrumental' function the employment plays for the individual at their particular point in the lifecourse. Our data suggest the employment situations most likely to impact negatively on mental health are those where job tasks are low-skilled/repetitive and completed in non-supportive social environments (in this study we found examples of bullying and verbal abuse by some supervisors in combination with very low wages). However, individuals reported the most distress when they also felt trapped within negative employment situations. If unpleasant employment was perceived as time-limited and as being used for a particular instrumental reason (for example to save for a holiday, new car or pay student debts) it could be tolerated. If, however, a life event (for example, a birth or relationship breakdown) forced the individual into unpleasant employment and they could not see a route out, then they were very likely to report their employment as having a negative impact on their mental health.

Data relating to the impact of respondents' employment on childhood to adulthood transitions, particularly from parental home to own home and family of origin, are complex and at points contradictory. For some respondents, the low incomes obtained through low-skilled work led to delays in setting up their own homes or starting their own families. For others it was precisely these transitions that led (or forced) them to accept and endure low-skilled factory employment, often in unpleasant social contexts.

This study has illustrated the importance of conducting micro-level qualitative research that complements pre-existing macro-level labour market/health impact studies. People live and make decisions in local areas, cultures and specific labour markets. They do not operate with perfect knowledge of national labour markets and commonly are not prepared to leave family and friends to seek work. Indeed, to the extent that many jobs in rural areas are acquired through local contacts (family and friends), relocation might actually prove disadvantageous. Evidence shows the differentiation of work into categories of *good* and *bad* is misleadingly simplistic. Rather, it seems sensible to consider the degree of fit between individuals' perceived needs at a particular point in their lifecourse, their employment and the available labour market opportunities. When employment does not meet perceived needs and there are no viable alternatives, young people are most likely to experience a loss of wellbeing and psychosocial health.

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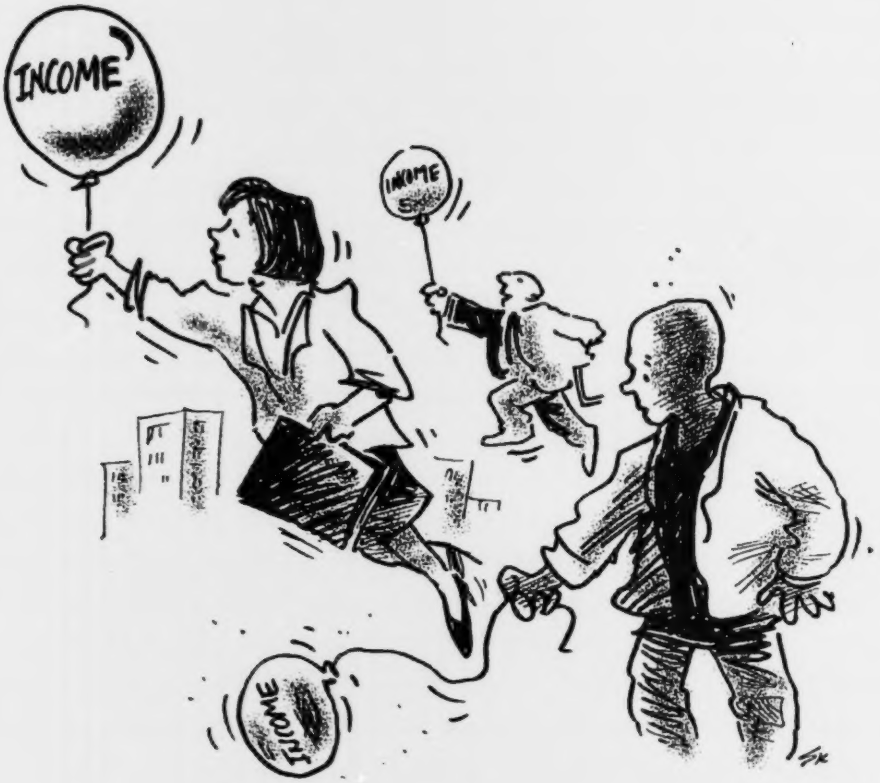
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7 Working towards retirement: promoting positive mental health among men in pre-retirement years

Troy Speirs and Martyn Wilson

Retirement and ageing have taken on increasing importance over recent decades. This chapter explores options for mental health promotion before retirement for men in the 50–65 year age group. Work has strong meanings for many men in terms of their esteem and sense of masculinity. As retirement approaches, men are challenged to find renewed meaning and purpose. We critique the notion of hegemonic masculinity by exploring expressions of masculinity that give meaning to men's lives. Expectations for retirement often centre on financial security and leisure activities, however health, a sense of freedom and social connectedness may influence their actual experience of meaningful retirement. When expectation and experience differ, adjustment to retirement may be complicated. We suggest many men do not plan adequately for retirement due to restricted interpretations of their masculine identity. Responsible, pro-active social and health policy is integral to bridging this gap between expectation and experience. Action-orientated, learning infrastructures could be developed to facilitate comprehensive, pre-retirement planning within the workplace. Having long been neglected, we recommend it is the responsibility of governments, unions, corporations and small businesses, as well as health care providers to reorientate the workforce to realistic retirement planning. We complement our discussion with four men's reflections on their pre-retirement and retirement experiences.

> He didn't get most jobs he interviewed for. 'I didn't tell them I was eighty-one', Edek said, 'I told everyone I was sixty-six'. He didn't seem to realise that sixty-six was already way too old to be applying for jobs. He did get one of the jobs...(Lily Brett, 1999).

Introduction

In recent decades, retirement has been celebrated as a period of rest, happiness and connection. However, many men find themselves lost in retirement with rates of depression, isolation, substance abuse and suicide reported as being high for older men (NSW Health Department, 1998). Personal and social role changes occur that can be complicated by associated adaptations to masculine identity. Men may struggle with the anticipation of these changes before retirement. Mental and physical health may deteriorate and adjustment to retirement may be compromised.

It is only during last 50 years that the sequence of school, employment and retirement has been the normal experience for most workers. According to Hirshbein (2001), in the 1930s, '40s and '50s, old age started to take on negative connotations where the authority about ageing moved from the people themselves to doctors and other professionals. Old age was defined as a problem. However, in the 1960s people began to realise many retired people were not really old. People are living longer and healthier lives when compared with previous generations (Commonwealth of Australia, 1999). They are mobile, fit, in good health and ready for work (Mulley, 1995). Older adults living in the community experience the best mental health across the adult life-span (Commonwealth Department of Health and Aged Care, 2000). This can be set against negative views about ageing that limit older people's participation in society, leading to isolation in retirement years (VicHealth, 1999).

With ever-increasing numbers of older people living longer, beyond retirement age, the transition from work to retirement has greater implications for the promotion of mental health. Upon retirement, men are challenged to engage in meaningful activity and form new connections with family and society. Many men do not prepare for their retirement beyond financial considerations. This can compromise their sense of meaning and mental health. Without continued meaning and purpose, many men may experience isolation, depression and a sense of powerlessness over their situation.

This paper explores options for promoting positive mental health before formal retirement for men in the 50–65 year age group. We analyse relevant literature in order to gain a fuller understanding of the relationship between expectations and the experience of retirement. This analysis is set against a background of understanding masculine identities and work, before exploring planning for retirement during the pre-retirement period. Although there are many issues upon which to focus, this paper addresses planning in relation to health, social connectedness, meaningful activity and finances. We complement our analysis with the reflections of four men: two in retirement and two in their pre-retirement years. We conclude with recommendations for pre-retirement planning and the promotion of mental health for this population.

Understanding masculine identities and retirement

In order to understand how ideas of masculinity are expressed in a certain period of time we need to consider social processes, ideology, relations of power, cultural activities and practices. The dominant socialisation of masculinity instils in men the ideals of dominance, authority, control, power and emotional repression (Levant, 1995). It is interesting the way some of these views of masculinity are accepted as being more legitimate and powerful than others (Edley & Wetherell, 1995). With regards to the legitimised view of masculinity, this evolves from the power of certain groups who force an interpretation of what masculinity should be and subordinate or repress other forms of masculine expression. Interestingly, hegemonic forms of masculinity can be defined by hierarchical social relations and need not be the most common form (Connell, 2000). Many definitions of dominant masculinity are seen as ahistorical, unitary, universal and unchanging categories, and the major discourses of masculinity are principally misogynist, homophobic and compulsorily heterosexual (Mac an Chaill, 1994). As an alternative, Connell (1995) argues for the existence of different types of masculinities stating that not all men benefit from the masculinised power structures in society. Many men live in a state of some conflict, be it explicit or repressed, with regards to their masculinity in relation to the dominant view of masculinity. The cost of attempting to negotiate this tension leads to possible rejection by peers, uncertainty in their social lives and ill health (Connell, 2000).

Some writers argue that a man is defined by what he does and his value as an economic commodity (Lee & Owens, 2002). This economic view of human capital in the public domain leaves a man coming to retirement with little room to move beyond this construct or idea of commodification. There has been much discussion about the 'patriarchal dividend' men acquire in our society. This is strengthened when a man works, has a family, has certain responsibilities and grows in the public domain, usually through career opportunities. Men benefit from being involved in these activities. Work has strong meanings for many men in terms of their esteem and sense of masculinity (Box A). Men coming into their pre-retirement years (>50–65) face loss of esteem if they fail to challenge the narrow construct of this dominant view of masculinity for themselves. Masculine values concerning productivity, interpersonal dominance, control and repressed emotions appear to influence how men approach preparation, planning and adjustment to retirement. We suggest many men do not prepare and plan for retirement beyond financial security due to the restricted interpretation of masculine identity outside of work and familial relationships. This may leave many men vulnerable to compromised mental health as experience of their masculinity changes when they come into pre-retirement and retirement years.

Box A
Men's comments on masculinity and work

BS: *...work means everything to me, I've spent most of my life there.*

JC: *...work keeps me busy and active. It provides friendships and companionship. It provides financial income and investment.*

RW: *...being able to work meant a lot to me as a man...felt fulfilled from work.*

GO: *...my positions were important to my identity...because they were important links within the college and theatre system where I worked...I managed to progress in my work and it gave me personal satisfaction...*

Alternate masculine values have emerged that encourage emotional awareness, expression and positive mental health. However, many men in the workforce approaching pre-retirement years may repress emotional expressions of their concerns about adjustment to retirement. Importantly, the more extensive men's emotional restriction the more difficulty they may experience in pre-retirement years as they face the reality of having to adjust to retirement (Cournoyer & Mahalik, 1995). But we must be careful; it could be construed from our discussion that men approaching or in pre-retirement years are rigid in their beliefs and behaviours and impervious to change! Not so. As suggested, the rigidity of gender roles and the dominant view of masculinity has been challenged. According to Connell (2002) there are multiple patterns of masculinity and these expressions of masculinity are somewhat dependent on the situation. Expressions of masculinity are viewed as social constructions created through the expectations of social forces such as parents, teachers, peers and the media, among other things, about what constitutes masculinity (Pleck, 1995). Men are actively critiqueing social constructions of masculinity and integrating these ideas with their lived experience, thereby expressing their preferred masculine identity (Connell, 2002). Therefore, a man could construct different and legitimate experiences of masculinity during pre-retirement years. They may need some assistance in order to promote and maintain positive mental health and social and emotional wellbeing. Men need avenues to explore how they can critique and express their masculinity in

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various situations; in this case, in the years just before retirement. This will have huge implications about how we as a society, and as individuals and communities plan for retirement.

Much has been written in recent years about masculinity and gender. We are not attempting a wide exploration of masculinities here per se. Suffice to say, we suggest that if men hold onto the dominant view of masculinity as a benchmark during their pre-retirement years, then they may not fully consider the planning implications for their retirement. Their expectations may well be incongruent with the actual experience ahead. We argue that men need to think beyond financial planning for retirement and start to think about linking planning to future meaningful activity, social connectedness and mental wellbeing. We look at the differences between expectation and experience before exploring planning and adjustment in pre-retirement years for men.

On expectation of retirement and actual experience

Many men find their expectations of retirement differ from the actual experience. It could be argued the greater the difference between expectations and experience the greater the difficulty men may have adjusting to retirement. So, what might the expectations of many men be? A little golf? Some reading and fishing? Time with the family? More time for travel? Are these reverie or achievable goals requiring a reasonable amount of planning? As previously stated, the dominant view of masculinity leaves men little room to think in different ways about success other than in the public domain. Retirement may be seen as a time of loss of status. Are their expectations loss of work, mates, meaning, purpose? If so, men may not adequately plan for their retirement for fear of the financial, self-perceptual, social and emotional changes they could experience in retirement. This potential denial of the changes ahead means it will be difficult for many men to bridge the gap between expectations and their actual experience of retirement. Generally, most men make financial plans for retirement as a way of bridging this gap. They are more likely to leave the workforce when they can financially afford to sustain a lifestyle without continued paid employment (Taylor & Shore, 1995; Beehr, Glazer, Nielson & Farmer, 2000). Their expectations centre on being able to support themselves and lead a quality lifestyle (Box B). But not all men can hope to experience a high quality of life. Many are asked to retire because they have reached retirement age regardless of their health status, fitness, financial security or capacity for further work. We acknowledge much research consistently indicates that financial security is the strongest single predictor of retirement decisions; however, we want to look further than financial security. As one way of understanding the nexus between expectation and experience concerning financial security for men entering retirement, we can examine the social determinants of mental health (psychosocial and environmental) at a population level.

Over the last 25 years Australian society has become increasingly divided between the rich, who hold most of the wealth, and the working and lower middle classes. The wage growth for those earning the average (NSW) salary of $37,100 (national average wage: $34,800) is much slower than comparative growth for wealthier taxpayers (Leys, 2002). This is confounded by government policy promoting self-funded retirement as necessary to ensure a lifestyle without the need for continued full-time employment. With the gap ever-widening, lower socio-economic status enclaves and communities will become increasingly exposed to consequences of social disadvantage including poverty, higher stress levels, a sense of continuing lack of personal control over the environment in which a person lives and works, leading to poor mental health (Commonwealth Department of Health and Aged Care, 2000).

Box B

Men's comments about expectations and experience

RW: ...*retirement was as he expected, except that he does not have 'any time' to pursue a full-time work related activity, like setting up a workbench. RW felt he would need 3 full days a week to make it a viable, rewarding and enjoyable activity.*

GO: ...*does not remember having any expectations when he retired from full-time managerial work (aged 60), but considered remaining in good health a concern – workplace and technology changes contributed to increased stress. GO moved from F/T to P/T work and retired in 2000.*

BS: ...*I hope to be less stressed, more relaxed, and do bugger all. I hope to have holidays, go shopping, be a grandfather, read a lot, and sleep longer hours. I hope to keep occupied.*

JC: ...*I hope to travel for six months, possibly to Europe, and have money to do that. I hope to receive a pension. I hope to have a job for a couple of days per week, perhaps in the local supermarket stacking shelves, not for financial gain though but rather to keep me be busy.*

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We suggest if men in pre-retirement years find themselves financially compromised, they will not adequately plan meaningful activity, a healthy lifestyle and adequate social connections beyond the family, etc. Many may think, 'Why bother if I'm not going to have the capital to realise my hopes in retirement?' It cannot be ignored that for some of these men their expectations and experience may be quite closely aligned! This despair may not only influence their desire to plan (or not) but also compromise their mental health. Our point is that social determinants for mental health could influence a man's confidence to engage in pro-active planning for retirement in order to bridge the gap between expectation and experience.

Economic stability may be important, but health status and other issues may be of greater influence to plans for retirement. Dwyer and Mitchell (1999) found retirement plans are more strongly influenced by health problems than economic variables. Consistently, research findings indicate there are a substantial proportion of individuals forced into retirement due to functional limitations associated with ageing and deteriorating health (Midanik, Soghikian, Ransom & Tekawa, 1995). According to Gall and Evans (2000), if men in their pre-retirement years identify retirement expectations as being physically active, financially secure, in good health and enjoying positive interpersonal relations, then these are significant predictors of a good quality of life for males six to seven years following retirement. This takes us beyond the expectations associated with financial security. Many men expect to be healthy on retirement, but appear to put little planning into achieving physical and mental wellbeing. Furthermore, little thought may be given to ascribing meaning and purpose to retirement planning. This could take us back to the discussion about dominant views of masculinity where men think they will always be productive and in control, while denying the need to plan non-competitive leisure, social and meaningful activities. For most men, the immediate effects of retirement are characterised by a reduction in stress (Midanik *et al.*, 1995). However, one line of research indicates approximately one third of male retirees found retirement to be a stressful event (Bosse, Aldwin, Levenson & Workman-Daniels, 1991). Retirement did not live up to their expectations. The difference regarding this aspect of health is a pointer to the unplanned nature of retirement for many men. Stress in retirement can come from boredom, unplanned 'leisure time', no purposeful activity and limited freedom from a spouse (Clitheroe, 2002). We argue that only attending to financial matters (if one can) in pre-retirement years means other expectations of retirement remain unchallenged through inadequate planning.

It has been stated the greater a person's wealth, the more freedom one will have to act in a way they wish. Yet, great and prolonged sacrifices of personal freedom centred on a structured work life occur before this freedom could possibly be realised. There are small rewards along the way, however it is in retirement (in a time ahead) where the real rewards of freedom lie. According to Saul (1992), this is why retirement has taken on such importance over recent decades; not so much because we are living longer. Continuing, he suggests there is every indication '...the promise of a freer future once we have ceased sacrificing our lives...' (1992, p495) is not convincing enough! This is evidenced by the increasing growth in personal anxiety and stress. It could be argued the pressure to realise this dream (read expectation) of freedom and happiness after so much sacrifice would be considerable for a man approaching retirement. How would this link with experience? Interestingly, upon retirement, not all welcome this sense of freedom! From their research into narratives about the retirement process, Jonsson, Josephsson and Keilhofner (2000) found some participants had trouble creating satisfying life routines once external demands on their time were removed. Some participants experienced a real void in their lives, while others looked forward to the freedom. Freedom is constantly promised in retirement, but can come at a price, and therefore must be realistically factored into plans for retirement.

We have argued many men encounter some differences between their expectations and the actual experience of retirement. Although financial security can bridge the gap between expectations and experience, other important considerations regarding when a man might retire include health, sense of freedom, social activity and generating meaningful activity. Boredom can become a major issue in retirement. The issues explored here are not exhaustive. All of this and much more needs to be planned for, especially in those pre-retirement years. We would like to offer some discussion and suggestions for pro-active retirement planning for men in their pre-retirement years, in order that men's experience of retirement could more closely resemble their expectations.

Planning for a mentally healthy retirement

Retirement is not a singular event, rather a complex transitional process. Since most men in pre-retirement years are active, healthy and independent they may be ready and able to respond to suggestions for enhancing their experience of retirement. As discussed, many men do not adequately plan for retirement. When a man approaches retirement, he may need the impetus and opportunity to plan and consider the meaning of his life beyond his retirement day. How could this be achieved? In this section we explore retirement planning and adjustment issues for men in their pre-retirement years, before offering recommendations for further discussion.

It has been suggested developing pre-retirement programs may be an effective method for assisting in men's disengagement from work, and facilitating their transition to retirement (Cude & Jablin, 1992). These programs could encourage men's planning by assisting them to examine their feelings and ideas about retirement. It could also offer an opportunity to work towards addressing some of the challenges that may lie ahead. According to Saul (2001), some large companies have started socio-cultural programs for employees and their families to redress the negative effects of relentless, corporation and market-centred activity. These programs have offered a range of activities including training, childcare, after-school care, summer camps and book clubs. Similarly, structured programs for men in their pre-retirement years may be feasible. Their place in large corporations and small business warrants further thought. Areas identified by retirees as important for discussion in pre-retirement years include:

1. How to achieve satisfaction with retirement through remaining active and connecting with family and friends.
2. Managing financial decisions and lifestyle concerns.
3. Exploring spousal relationships and consolidating plans for retirement.
4. Considering the consequences of taking an active approach to retirement preparation (Rosenkoetter & Garris, 1998). Importantly, men who have been involved in broad planning programs and gained support for planning their own retirement, report great appreciation of such opportunities (Mulley, 1995). Regardless of expectations, a pro-active approach to meaningful and realistic retirement planning appears appropriate to assist men extend planning beyond that for financial security. The challenge will be developing pre-retirement planning programs sufficiently individualised for different types of workers that facilitate effective adjustment to retirement.

Transition to retirement requires creating interests and activities in pre-retirement years that flow beyond the retirement day. Typically, hobbies, physical exercise, travel and social interactions form the foundations of activity in retirement. Importantly, the use of leisure time to engage in hobbies and connect with family and friends has been reported to improve retirees' satisfaction and quality of life (Mishra, 1992). However, Margo

(1996) argues such activity should be introduced gradually in the course of retiring rather than as a sudden and abrupt transition. When men attribute much meaning and purpose to work and the status it provides them, the sudden transition to retirement may be met with apprehension. While some retirees' expectations may be governed by sudden and complete transition from work to retirement, other retirees may prefer to undertake some form of semi-retirement (Ekerdt, DeViney & Kosloski, 1996). Semi-retirement is important in current times as the nature and definition of retirement undergoes change such that retirement does not necessarily mean total and permanent withdrawal from paid work (Talaga & Beehr, 1989). Men's thinking about retirement in this way may support their transition from work. It has been reported that re-employed retirees experience better social adjustment than non-employed retirees (Jayashree & Rao, 1991). Voluntary work is also proffered as an option for retirees (Commonwealth of Australia, 1999). More than 20% of people over 65 years of age work as volunteers giving service to others, the vast majority of older men being capable of being productive and making a contribution to their community (Sax, 1993). Regardless of choice of activity, men have been reported as experiencing retirement satisfaction when involved in engaging occupations or activities (Jonsson *et al.*, 2000). Clearly, there are many opportunities for men remaining active that may facilitate continued meaning and purpose. While the above discussion centres on men needing to plan for meaningful activity in retirement through work or work-related (voluntary) activities, it is acknowledged 'work' is not the only way to achieve this outcome. Hobbies, interests, physical exercise and social networks can provide much meaning for men and are integral to the planning process.

Financial decisions and lifestyle concerns are other aspects of retirement that weigh heavily for men. Planned activity that men may need to consider include saving programs, the purchase of investment property, pension eligibility, and locating oneelf for post-retirement activity (Ekerdt *et al.*, 1996). Subsequently, pre-retirement planning should seek to engage men to further explore their financial position, the meaning this holds for them, and the impact this has on lifestyle opportunities during retirement. Expectations surrounding complete retirement and semi-retirement can be placed in a much fuller perspective when a man's financial position is factored in. Regardless of individual circumstance, providing support to men in exploring their financial decisions and lifestyle concerns may present as an attractive option. We suggest planning with regard to financial security be integrated with other aspects of retirement planning, for example, how to manage time, 'freedom', relationships, meaningful activities, maintaining mental and physical health etc. Such an approach could work towards alleviating the despair some men may experience when financial security is discussed exclusively in retirement planning. This suggestion builds on the idea of developing workplace pre-retirement programs by affiliating broader planning and adjustment issues with planning for financial security.

Another important issue with a significant bearing on the quality of men's retirement is their relationship with their partner and family. Men who spend extensive amounts of time at home in the domestic territory of their spouse may become bored and irritable, thus contributing to resentment emerging in the relationship (Colling, 1992). Consistently, it has been reported there is an increased incidence of marital breakdown during retirement years (Mulley, 1995). As such, decisions surrounding retirement should be conceptualised as a joint activity between a man and his partner (Midanik, Soghikian, Ransom & Polen, 1990). Accordingly, families provide the ideal environment through which men may realise their desires and apprehensions while undertaking retirement planning. Dialogue should be encouraged between couples and within families to examine the range of feelings and ideas that prevail about retirement (Rosenketter & Garris, 1998). Such an approach to planning corresponds with men being more likely to confide in their spouses and close family relations about their feelings. This emphasises the importance of men involving their family in retirement planning and may provoke consideration of the changes that may emerge in their relationships (Box C). Such an approach will serve to consolidate the retirement plans of men so as to suit all involved and more closely align their expectations with their experiences of retirement.

Perceptions of retirement planning do not always correspond with retirement preparation and those people who have poor or no pre-retirement planning may find retirement to be vastly different from what is expected (Rosenkoetter & Garris, 1998). It appears those who actively plan for change in retirement actually participate in those activities, as opposed to those who think they may, once retired. This reiterates the complexities of the retirement process for men – it being a transitional experience with possible negative impact on life pattern changes, psychosocial adjustment and mental health. Therefore, planning for a mentally healthy retirement and addressing the above issues would be a beneficial process during pre-retirement years. But some central questions remain. If comprehensive planning opportunities are to become available for men while still at work, then who might take the responsibility for such action? Where could the funding come from, and where might this planning take place? We wish to make some recommendations for open debate about men's retirement planning and the promotion of mental health.

Box C
Men's comments on planning

GO: *I didn't do any planning for retirement, it all just happened...I got involved in Balwyn Bowls, picture framing, art classes, painting watercolours...*

RW: *I saved and invested...looked through a few books in order to think about setting up a workshop....happy to retire...no real adjustments to retirement.*

BS: *I expect something will happen for my retirement, I don't know yet, I'm undecided.*
I don't want to waste away. I want to do some work, maybe 3 days per week, any work I can get really, welding, drive a church bus, simple tasks that are less stressful. I might go to church. I don't know this will be achieved.

JC: *My plans for retirement all depend on having money. Friendships are not an issue; I have not given it much thought. I acknowledge that they may move away. I have not given much thought to other things like my hobbies, it all depends on money and budgeting.*

Conclusion and recommendations

Retirement can be a time in men's lives to become enriched after full-time employment. We have explored some issues centring on masculinity, expectations, planning and adjustment in pre-retirement years while offering some suggestions along the way. We would like to conclude with some final recommendations, born out of our analysis, that men, unions, social planners, mental health promotion workers, various businesses and government departments may wish to examine for the betterment of men moving towards retirement.

Our recommendations are:

- Review and/or draft national and state government policy in onsultation with workplaces, small business associations, unions, employer groups, and relevant government agencies. Policy should address provision for men's pre-retirement planning and promotion of positive mental health during retirement. Governments or associations to provide incentives to engage men in pre-retirement years to address and plan for their retirement.
- Develop government, union, and workplace strategies to introduce a range of workplace practices addressing complete and partial retirement options.

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- Re-orientating community attitudes regarding retirement and ageing through continued public program and media campaigns.
- Conduct workshops in the workplace for men to explore their needs in retirement during their pre-retirement years – specifically preparation and planning activities.
- Engage with banking and financial institutions to explore the feasibility of affiliating financial management plans with planning for future social and emotional wellbeing. This would require full support from the relevant government departments.
- Support small businesses to effectively engage in the implementation of workplace initiatives to assist men in their transition to retirement. We are aware small businesses are the largest employer in Australia, but most likely do not have the resources to conduct pre-retirement programs.
- Develop a public information strategy targeted at men and their families in pre-retirement years, promoting planning and positive mental health during retirement.

We suggest the Commonwealth Department of Health and Aged Care take on the coordination and funding of such activities with employee and employers' industrial associations working together to generate a sustainable and constructive, wide-ranging mental health promotion strategy. By setting up planning strategies in these ways, all key stakeholders, including men themselves, have the opportunity to contribute to the promotion of continuing meaning, purpose and positive mental health in retirement.

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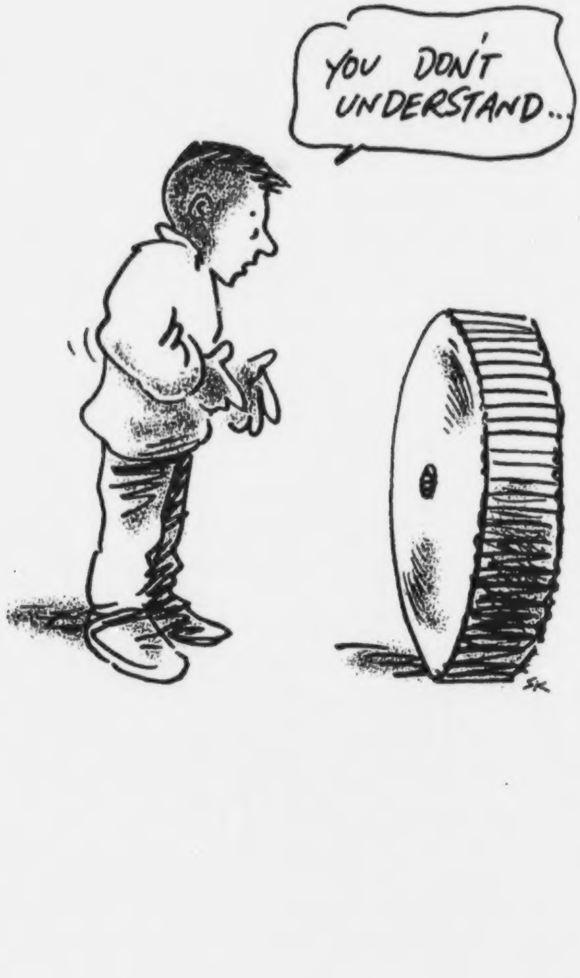

8 Challenges for women combining caring work with employment

Alison Rosser

A constant characteristic of health service reform over the last decade has been a redistribution of resources away from residential services towards community care services, for economic and philosophical reasons. Care at home by carers providing unpaid labour involves the least public costs, but substantial private costs. Caregiving and support is provided by informal carers, largely women, who are usually partners, relatives or friends of the person cared for, often at the expense of their own health, social and emotional wellbeing, financial status, career potential and opportunities. In this chapter I examine some issues for women who are attempting to balance their caring responsibilities with employment.

Women and caring work in Australia

Unpaid caring and caregiving at home, for dependent populations, is work largely undertaken by women (Traustadottir, 1991). In Australia, it is estimated 2.3 million people, 70% of whom are women, provide care to a person who is frail aged, disabled or has a chronic physical or mental illness (Australian Bureau of Statistics, 1998). The Office of Women's Affairs estimated in the mid-1990s that women carers at that time – providing caregiving at home for others, with only scarce respite – contributed about $6 billion in unpaid labour to the nation. (Office of Women's Affairs, 1994). In 2001, the Carers Association of Australia estimated carers' unpaid work contributes $16 billion to the national economy. Approximately 50% of these carers are in full or part-time employment (Carers Association of Australia, 2001).

Factors affecting the ability of women who provide care to others to stay in work or enter paid work are complex, and may be broadly grouped as being internal or external to the family caregiving situation (Turvey & Thomson, 1996). Internal factors relate to the characteristics of the caregiver, the career and the amount of informal support available to the family. External factors include workplace conditions, income support and support services. Many carers lose working time when caring for a family member with a disability, mental illness or who is aged, which may seriously interfere with career potential and opportunities (Schultz & Schultz, 1989). Long-term care responsibilities are likely to lead not only to loss of income but also to loss of career opportunities, status and seniority within the paid workforce (Olsen & Wotton, 1997). The following case example reveals some of the issues for carers who try to maintain or return to work.

> Mary's husband, Peter, retired from work at age sixty to help Mary run her commercial kitchen business. Mary watched her husband's health deteriorate when the complications of treatment for leukaemia brought on a form of dementia and Peter became disoriented and lost his short-term memory. Mary continued to maintain her cookery business for a while alone but stopped when it was necessary for her to take on full-time care of her husband. Mary returned to her career on a part-time basis after her husband died and has spent much of her time lobbying for supports for people with dementia and their carers.

Mary's issues were:

- she found it difficult to maintain work while she was undertaking the caring role
- she had to accept a reduced income
- she would have liked to continue working fulltime provided she had more help with the caring role
- Mary was so busy caring she did not know where or how to try and get help for herself or her husband
- she felt very isolated and disempowered for the four years she maintained the caring role
- she didn't have time or energy to develop her own abilities, health or wellbeing
- respite – half a day per week – 'came too late'; it was needed from much earlier in the progression of her husband's illness.

Mary's needs were:

- emotional support, which would have helped her to continue paid work and caring
- practical assistance such as home help, companionship for Peter, and help in accessing day activities or outings
- a carer payment would have helped cover some of the additional costs of caring
- opportunity to 'have a say' in the care planning and management with service

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providers; this would have been appreciated.

Carers, health and wellbeing

The *Health and Wellbeing of Carers* survey, conducted by the National Carers Association (2001), reveals many carers are being harmed physically, mentally, emotionally and socially because of their caring responsibilities. The study examines what practical and emotional support carers receive, how much time they spend providing care and how being a carer has impacts on their life opportunities. It was found carers experience stress, social isolation and loneliness, changes in relationships and grief. They feel sad and depressed, worried and anxious. Nearly 60% find their opportunities for travel, pastimes and paid work are affected (Carers Association of SA Inc., 2001). These stressors create negative impacts on a carer's emotional and mental wellbeing. On the other hand, there can be psychological benefits for carers who remain in paid work (Lewis, Kagan, Heaton & Cranshaw, 1999; Lankshear & Giarchi, 2000).

Building relationships for care

The lives of families can be enhanced if they are encouraged to consult with professionals about the optimal management of their care. Honig and Winger (1997), and Turvey and Thomson (1996) found stress levels were lower when carers have professional agency support. Working in collaboration with health professionals and service providers can provide carers with a greater sense of freedom and control over their own situation.

The Mental Health Council of Australia (MHCA, 2000) *Enhancing Relationships* report recommends policy initiatives that encourage change, overcome negative attitudes and foster collaboration between families, community and professionals. As the Report states:

> Interaction between consumers, carers and health professionals should be based on people first, and not on a diagnosis or professional title (p2).

Carers should be included in policy development and be involved in developing strategies for training, education and quality assessment of community service delivery.

Developing a concept of shared care encourages professionals to work within a framework of carer networks, rather than responsibility resting only with the principal carer. A report by Holmwood and colleagues on primary mental health care in Australia for the Federal Government, suggests 'shared care' has been loosely defined both in practice and in the literature. Generally, it refers to 'the cooperation between specialist care-professionals (psychiatrists, psychologists), service providers and general practitioners' (Holmwood, Groom & Nicholson, 2001, p14). Within this definition, at management level, carers and consumers are only regarded as educational resources for consumer and carer groups, and non-government organisations. Alternatively, Holmwood *et al.*, (2001, pp14-15) recommend a framework of collaboration that is oriented towards relationship building between all stakeholders at all levels of the care process – through service agreements, care planning, case conferencing, communication tools, and liaison with consumers and carers. They found extensive barriers to collaborative activities still exist, despite specific funding over the past decade, and 'most programs have yet to reach a level of systemic change' (Holmwood *et al.*, 2001, p8).

Policy initiatives

In some countries, small policy changes are occurring. Governments have included carers in policy initiatives such as the British government's *Welfare to Work* employment initiative and the strategy document *Caring About Carers* (DoH, 1999). Those initiatives focusing on 'family friendly' workplaces make small inroads into balancing the demands of family life and employment. The *Report of the Consultative Conference on a National Strategy for Carers* (DoH, 1999) indicates having the option to continue working links with quality of life outcomes.

Policy should recommend the sharing of economic responsibility between the family and the formal system:

> Economic expenses of families should be viewed as a resource contribution and not as a burden (Franks, 1990, p10).

By not providing such support, the health and emotional wellbeing can break down in carers who need support themselves. Kilner (1996) advocates carer assessment within the service provision framework and promotes three necessities for carers:

1. Adequate care for the consumer.
2. A collaborative approach to care.
3. Quality of life for the carer.

The value of social support and the sense of belonging and being cared about can make considerable differences to the psychological wellbeing of a family.

Traditional employment practices and attitudes need rethinking. As we progress in the twenty first century, increasingly more women are either sole-parents, widowed or divorced. As such it is necessary for them to earn a living while at the same time caring for a family member in the home environment. At present, gender appears to affect the expectations and distribution of care responsibilities.

I have considered here some of the issues and challenges for women who are trying to combine caring work with employment. There has been a slow and steady progression forward for women carers. If we are to move towards greater freedom and quality of life, a new agenda needs creating that allows caring women to be more assertive in stating their needs. Women require greater options in their lives so that caring work and employment can be combined with limited stress or guilt. Caring and paid work can be combined if workplaces are flexible and responsive to the needs of carers. Women as carers and as workers should be encouraged to foster their own sense of health and wellbeing.

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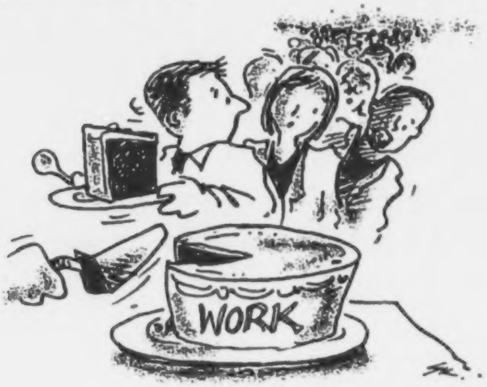

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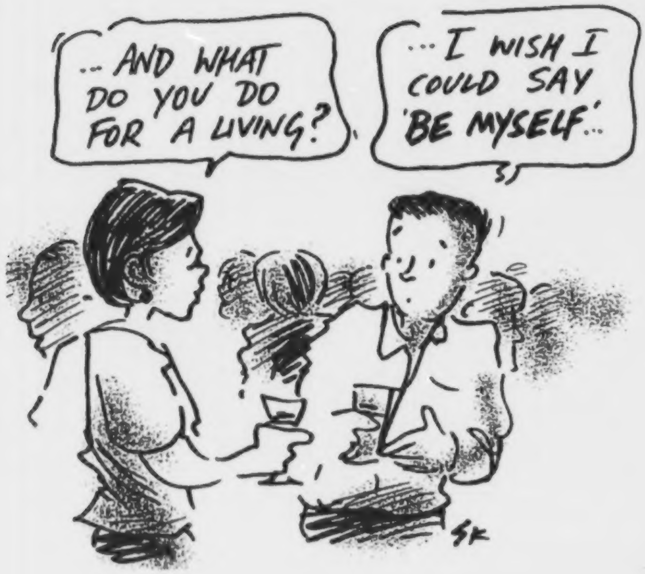
... AND WHAT DO YOU DO FOR A LIVING?
... I WISH I COULD SAY 'BE MYSELF'...
SK

Section III
Work and safety

The organisation of this section around safety focuses on organisational and social practices which harm individuals, and constitute fundamental abuses of human rights and human dignity. The contributions are clustered around practices that make work unsafe emotionally, psychologically and sometimes physically, with potential physical and mental ill health outcomes not only to workers but to colleagues and family members. *Un*safety at work for individuals may have tragic sequelae. The economic cost to organisations, industry and communities is inestimable. Common to each of these contributions is their focus on the preventative and health-promoting possibilities of educational strategies and attitude change.

There has been, and continues to be much attention directed at certain settings, especially health care settings, as being increasingly violent. Psychiatric, emergency and aged care settings are frequently represented as contexts of increasing aggression, with particular emphasis on the occurrence of physical violence and injury. While physical violence towards workers in the conduct of their work should not be tolerated, it has been increasingly identified in a large body of Australian and international literature. Arguably, it is becoming somewhat more amenable to occupational health and safety legislation governing safe working conditions, as well as pursuance under criminal and civil law. As a result, we are starting to see the emergence of industry and government strategies such as Zero Tolerance for Violence against Nurses in NSW.

However, covert manifestations of violence in employment are often tolerated, entrenched, invisible and difficult to counteract, and are certainly not the sole province of health care settings. Bullying, racism and other forms of discrimination, and aggression and disempowering behaviours within work teams as part of accepted practice, are harmful to the mental health of individuals and those around them, and may indeed have tragic outcomes.

Lyn Turney explores some of these accepted ways of operating which she argues are particularly resistant to identification and intervention because they are intricately entwined with the process of training. Socialisation into the professions such as medicine or law, or in trade apprenticeships, frequently incorporates and fosters behaviours that easily translate into workplace bullying practices. Turney argues that new organisational structures and practices arising from market-driven reforms may have exacerbated these harmful practices, and may further entrench the potential for the exercise of administrative and professional power in the form of workplace bullying.

Charmaine Hockley examines the impact of workplace violence on third parties. The issue of workplace violence is most often conceptualised in terms of victim and perpetrator. Hockley's study of workplace violence demonstrates not only the huge human costs on the primary targets but also on those close to them – colleagues and family members.

When VicHealth recently launched its *Together we do better* campaign to promote mental health across the community, certain elements of the campaign, in particular the links between bullying and health, struck a chord within the community. To support the campaign, VicHealth commissioned a community attitudes survey to assess and gain insight into Victorian attitudes towards bullying and bullies. Melissa Corkum's paper documents the astonishing findings revealing Victorians' widely held perceptions of a culture of bullying which exists across government, media, schools, workplaces and sporting circles.

In the final paper of this section, Cath Roper introduces the important, emergent work that is called 'consumer perspective employment' within the psychiatric service system in Victoria. Consumer perspective employment refers to work undertaken by consumers of mental health services 'trading' their consumer experiences and activism as part of a reform agenda to modernise mental health services. Personal safety for these workers becomes a very slippery thing when constantly faced with the persistent, pervasive and damaging stigma of having a mental illness, that is, in others' perceptions of them not as a competent co-worker, colleague or educator, but primarily as a person with a mental illness. Similarly, being placed in contradictory locations in relation to advocating on behalf of mental health service clients, vis-à-vis the organisation, becomes a place of unsafety. Roper challenges us with many questions. What constitutes safe work for consumer perspective employment? What makes this work precarious? How do consumer consultants assess the health of organisations in which they work? In posing these questions we would argue that from their unique position, consumer perspective employees share a great deal of common ground with their (professional) mental health service colleagues.

9 Mental health and workplace bullying: the role of power, professions and 'on the job' training

Lyn Turney

Study of the professions, and the process of professionalisation as an occupational strategy, has mainly concentrated on investigating structures of power, rather than individual and deliberate use of power. This chapter provides a microanalysis of power relations by examining professional power and hierarchy in interpersonal relations within the workplace. It makes links across the spectrum of workplaces in which bullying occurs – from those where physical intimidation and threat of violence is experienced, to the professions and quasi-professions where legitimate power becomes the vehicle for invisible bullying practices. Arguably, it is within the professions that bullying occurs in its most rarefied form and, to understand the phenomenon, I argue that we should closely examine instances of workplace bullying where there is no one tangible or definable act but clearly an ongoing threat to an individual worker's health and safety. In particular, I explore the positionality of the traditional professions within new organisational structures. The paper concludes with recommendations for the promotion of mental health at work that focus on both environmental and individual strategies.

Introduction

W*orkplace bullying* is fundamentally a health and safety issue and can be defined as a practice separate from, but related to, other forms of bullying. In this chapter I challenge the primary focus on individual victims and perpetrators as sites for change through processes of mediation and instead analyse power relationships and workplace structure and non-structure. In particular, I examine the professions – where workplace bullying reportedly occurs more frequently. Insights are drawn both from participant observational work within the health and human services sectors and from an in-progress study involving in-depth interviews with people who have experienced workplace bullying. Examples are used to make broad links across the spectrum of workplaces within which bullying occurs – from those where physical intimidation and threat of violence is experienced, to the professions and quasi-professions where legitimate power can be the vehicle for invisible bullying practices.

Defining workplace bullying

In the last decade, workplace bullying has been identified as a significant occupational health and safety issue both in Australia and internationally. The Australian literature reveals considerable problems with definition and the categorisation of bullying behaviours, with the result that definitions are generally broad and inclusive of a range of behaviours (e.g. Ellis, 1997; Queensland Workplace Bullying Taskforce, 2001; The Wallis Group, 2001; Victorian WorkCover Authority, 2001). An all-encompassing approach though is problematic because, as Einarsen and Mattieson (2002) note, if everything is defined as bullying then nothing constitutes bullying - that is, by being all inclusive, the term loses its meaning and its usage instead serves to trivialise and negate the serious impacts of workplace bullying on the mental health of workers, on worker output and on the health and safety of the workplace itself. Workplace bullying is sufficiently different from schoolyard bullying and other bullying behaviours, exemplified in sport (The Wallis Group, 2001) to be considered a separate and actionable practice because, in its most severe form, ongoing exposure to it can cause severe psychological trauma similar to that experienced by victims of torture and domestic violence (Einarsen, 1999; Field, E. 2002). Workers so exposed report feeling angry, helpless, stressed and depressed and sometimes are unable to return to work (Richards & Freeman, 2002).

Workplace bullying can be defined as inappropriate interpersonal behaviours that workers are subjected to by virtue of their employment. It includes such things as persistent and unjustified criticism, constant scrutiny of work or unfair allegations of incompetence or insubordination (Bernardi, 2001), or ongoing criticism, threats or behaviour towards a person that intimidate, humiliate and/or undermine their capacity to do their work (Victorian WorkCover Authority, 2001). The consequence of bullying is that it undermines the dignity and self-worth of individuals who become less productive, may suffer trauma-related illnesses, be at greater risk of self-harming behaviours and who may be dismissed, miss out on promotion opportunities or quit their jobs without having a new job to go to (Bernardi, 2001; Strawbridge, 2001). For employers, workplace bullying can lead to absenteeism, high staff turnover, decreased morale, loss in productivity and payment of legal costs to defend claims of unfair or constructive dismissal. In Australia, the financial cost to industry has been estimated to be between A$3 and A$36 billion per year (Richards & Freeman, 2002). Tim Field, an anti-workplace bullying campaigner, sums up the workplace effects of bullying in this way.

> Bullying is not tough management. Its purpose is to hide inadequacy and [it is] a form of thuggery which prevents people from doing their job. Where bullying exists [you will] find disenchantment, de-motivation, demoralisation, disenfranchisement, disempowerment, disloyalty, disaffection, dysfunction, inefficiency, cynicism, alienation and an 'us-and-them' culture, constant conflict, an unpleasant atmosphere, misery, unhappy staff, a climate of fear, high staff turnover, high sickness absence, low productivity, impaired performance, stifled creativity, low morale, zero team spirit, poor customer service, and mistakes in delivery of products and services. The cost of these is rarely accounted (Field, April 29th, 2002).

The mental health effects of workplace bullying

The effect of workplace bullying thus clearly manifests as an injury sustained in the process of doing one's job; a central and, in many ways, a captive activity in the life of most people. It is the centrality of work to an individual's life and sense of self that is at the core of the harm workplace bullying does to those who are targeted. Continual criticism, unmanageable workloads, and the uncertainty afforded by ongoing lack of security and support in the workplace undermine self-esteem and the ability to perform everyday work tasks. This then affects mental health and ultimately the ability to do the job. One lawyer reported saying 'he was so browbeaten by a bully that he could not compose a basic letter without fear of reprisal; he felt that he had lost the capacity to complete a basic task' (Toop, cited in Richards & Freeman, 2002, p233). If workplace bullying has been experienced by 50% of Australian workers as reported by Morgan and Banks (1998), then loss of productive time, both in the workplace and in dealing with and recovery from trauma related injury, is a substantial social cost. In most people's lives work itself is mandatory, essential for survival and not always where individuals would choose to spend most of their time. So when a worker experiences the traumatic effects of bullying, financial constraints often make it difficult to speak up in self-defence or to escape the workplace (Einarsen, 1999).

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Workplace bullying and violence

Bullying in the workplace first came to notice in what could be described as apprentice bullying through high profile case studies, presented in the media (e.g. South Australian Employees Bullied Out of Work, 2001). In cases that have been litigated, it has been the associated physical violence that has been highlighted and prosecuted rather than the trauma associated with loss of self-esteem and employment. In fact, violence or its threat is a key feature of both schoolyard and apprentice bullying, while it is usually absent in professional organisations. And, although it would seem the workplace cultures in trade and professional organisations are qualitatively different, I will make some links that promise to be elucidatory. Rayner and Hoel (1997) outline several categories of intimidating behaviour at work, unrelated to violence but directly relevant to job specific threats: threats to professional standing; threats to professional status; isolation; overwork; and destabilisation. Examples they provide include: belittling comments, public professional humiliation, shifting goalposts and undue pressure to produce work. When these and similar activities are ongoing they constitute workplace bullying and are likely to have deleterious effects on the mental health of the person who is subjected to such treatment.

So, in order to understand and address the phenomenon of workplace bullying, there is a need to closely examine instances of workplace bullying where there is no one tangible or definable act but where there is clearly an ongoing threat to individual workers' health and safety. Workplace bullying always occurs within a power relationship and, in professional and semi-professional contexts, it is rarely connected with physical violence and is only sometimes related to harassment. Arguably, it is within the professions that workplace bullying occurs in its most rarefied form and a focus on the professions, particularly medicine, provides the possibility of a unique window into bullying practice.

The professions, professional power and workplace bullying

The study of the professions has mainly concentrated on investigating structures of power, rather than individual and deliberate use of power. The power of the professions is seen as structural and organisational, having been achieved through systematic and strategic manoeuvres to gain monopolistic and prestigious market positions (Freidson, 1986; Turner, 1987; Willis, 1989b; Daniel, 1990; Daniel, 1998) In this view, individuals within the professions are seen as inheriting prestige and power by virtue of their occupational choice rather than individually seeking or exercising it. To date there has been no critical investigation of the micro interaction of professionals nor their interaction with subordinates. Yet it is clear that hierarchy exists in any interaction with professionals in the work context. What has been investigated within the profession of medicine is the doctor-patient relationship (e.g. Katz, 1986; Barbour, 1998) and these studies have identified two main issues. The first is a clear imbalance of power and professional distance manifest in what is commonly referred to as the 'empathy gap' or fundamental lack of understanding of the lived experience of 'the other' - what anthropologist Clifford Geertz (1993), in referring to the relationship between himself and the native subjects of his research, terms as being 'profoundly other to each other'. The second and related concept is that the professional and the lay person inhabit different worlds and do not even share the same understandings of common sense terms (Boyle, 1970) - what educational researcher Bernstein (1974) refers to as having differing linguistic codes. These analyses provide insights relevant to professional power in its interface with the patient, but it is what happens in the shared world of work within the professions and with their subordinates that has largely gone uninvestigated.

Vertical workplace bullying and the professions

There have been several recent reports of bullying in medical settings that provide rare insights into the closed world of health professionals (Quine, 1999; Editorial, 2000; [anon. 2001]; Dyer, 2001; Strawbridge, 2001; Sunderland & Hunt, 2001). The practices discussed can usefully be divided into two main analytical categories: horizontal workplace bullying and hierarchical workplace bullying. The former has been written about in a number of nursing related publications (Duffy, 1995; Lee, 2001; Strawbridge, 2001; Hockley, 2002) and refers to workplace bullying that occurs between workers or professionals on the same level, in the same occupation. Whilst a full discussion of this type of workplace bullying is beyond the scope of this chapter, it is worth noting that it is a practice engendered within a broader culture of bullying. The main focus of this analysis is the bullying that occurs within hierarchy and by virtue of an individual's structural location both within a specific workplace and within the broader world of work.

It is within the professions that interpersonal hierarchy is arguably most obvious and where power disparity is greatest. A recent study of

5000 Australian employees reported the legal profession to be the worst bully with 33% of respondents in the sector saying they had experienced regular intimidation at work ((TMP Worldwide, 2002; The Age, 2002). In Britain, a study of the public hospital sector, an NHS Community Trust, reported 38% of health sector employees experienced workplace bullying in the previous year (Quine, 1999). The same study reported specifically on junior doctors, 37% of 594 who identified as having been bullied in the past year (Quine, 2002). In the United States several studies have shown medical students suffer high levels of job related bullying during training that escalates with progression through training (Daugherty, Baldwin & Rowley, 1998; Kassebaum & Cutler, 1998). The only available report in Australia identifies high levels of bullying during medical training but names it as sexual harassment (White, 2000). In fact, it seems socialisation into the professions through training frequently incorporates and fosters behaviours that easily translate into workplace bullying practices. However, because they are intricately entwined with the process of training, they are particularly resistant to identification and intervention.

Learning power and hierarchy - professional training and practice

In examining the process of professional training, I use two case studies to illustrate my analysis. The first was an interview with a young man who, after six months, had quit his job in a very eagerly awaited apprenticeship as a chef in a top regional restaurant. The second is an anonymous account of the experience of a young woman trainee surgeon published as a commentary in the British Medical Journal. Both experienced ongoing unfair and unreasonable criticism undermining their work and their abilities from a single person who held a formal position of power over them.

Although, at first glance, we might see these cases as completely different, there are similarities that are explanatory in understanding the structure of power that enables its individual and deliberate use. In both these cases the young people were undertaking practical, on-the-job training - a hands-on approach in the form of 'learning from the master'.

CASE STUDY 1 – the apprentice chef

The apprentice explained that the head chef would constantly find fault with his work, tell him that he would never make a proper chef, often throw the dish he was working on in the bin in a flight of rage, continually criticise and, on several occasions, 'clipped him round the ears' (read: hit him across the head). At the same time, the chef refused to sign the apprentice's indenture papers over the six-month period, ensuring that the apprentice was not in a position to stand up for himself and affirming that he was dependant on the good will of the chef. Episodes of bullying were, however, frequently followed by an invitation to join the chef in a drink after work, at which time he would apologise and say he did not mean the things he said – he was just trying to make a good chef out of him. The apprentice finally resigned from this position. When asked why he resigned – was it the physical violence or the criticism – without hesitation, he answered that it was definitely and unequivocally the latter.

CASE STUDY 2 - the trainee surgeon

The tears ran down my face, hidden by my surgical mask. My consultant continued relentlessly, 'Why can't you do this? It really isn't hard. Are you stupid? Can't you see how to help me?' ... The criticism continued, if not with words, then with sighs and angry tutting. The atmosphere in the operating theatre was tense. The staff had all seen this happen many times before - hard working, pleasant trainees reduced to non-functioning wrecks in the space of an operation. I looked helplessly at the scrub nurse, another trainee. She saw my distress immediately and gave me a supporting glance. But she too was suffering. 'No, not that one. Why do we have to have trainees in my operations? Not like that,' she lashed out at the scrub nurse. Another hard working, competent trainee, now shaking and anxious, her self-confidence fast diminishing. ... I felt uncomfortable continuing in such distress. ... I wondered what would happen if I asked to leave and decided that it would probably just make things worse for me. I stayed. Three hours of hostility and criticism. ... Her behaviour was always the same - on the ward rounds, in clinics, and in theatre. She was hostile, critical, and discouraging. I continued in this post for the complete six months, becoming increasingly anxious and depressed. I left my post feeling suicidal. ...The bullying I endured has left me traumatised. Despite being told that she treated everyone this way, I believed it was all my fault ... I couldn't believe that this was the basis of basic surgical training ([anon.] 2001, p1314).

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They are their masters' apprentices, and the methods of formal training in the professions of medicine and law (and also, to a lesser extent, in nursing, social work and teaching) incorporate the practicum, the internship and the article-clerkship, all of which parallel trade apprenticeship training. In the professions, but also in the trades, the master controls knowledge, the work itself and has inordinate power over results and future job prospects. The master elicits perfection and precision – there is no place for the mediocre. But the trainees are high achievers, top ranking, successful and disciplined students who put long, hard and solitary hours into their achievements. This makes them extremely vulnerable. They are not in a position to jeopardise their career by speaking out about abuses of power nor to contest the mythical notion that tough discipline and cold, unemotional interpersonal relationships make them better practitioners.

In terms of workplace bullying, the main difference between the trade apprentice and the trainee professional is that the former is subjected to working-class bullying behaviours that are, in the main, overt and more likely to be accompanied by violence or its threat (and therefore more actionable); whereas professional workplace bullying occurs in the form of verbal or non-verbal criticism and intimidation that is subtle, insidious and almost impossible to detect from outside the interpersonal relationship. Both forms threaten mental health and wellbeing.

The master-apprentice relationship is sacrosanct and immune to intervention. This is particularly the case in medicine, which is an autonomous, individualistic and largely competitive practice, where there is no allowable margin for error. The master cannot be wrong. Internal regulation of individual members is integral to the maintenance of professional power. As Daniel argues in relation to the legal profession:

> Disciplinary practices are about learning and loyalty, standards, sanctions and the solidarity of the group. Whatever might threaten from outside is vigorously resisted and what might corrupt from within is to be cut out. Maintenance of identity, public face and reputation can become its paramount good (Daniel, 1998, p3).

Daniel (1998) uses the notion of 'scapegoating' to explain how a lawyer was sanctioned by her profession. She refers to 'professions as community', as tight-knit, exclusive, collegiate and closed groups that are both self-serving and self-regulating. As a bonded group with shared beliefs and practices, doctors and lawyers have a common interest in perpetuating their considerable advantage and prestige, so they do not tolerate individual resistance and those from their ranks who transgress are punished and penalised. Hierarchy and power is learned, reinforced and reproduced within the master-apprentice relationship. It is redeployed and duplicated in other workplace relationships, such as the nurse-doctor, nurse-nurse and administrator-doctor, and professional dominance over other workers becomes a necessary occupational mode of operation. And, at a broader societal level, professional power is sustained in professional autonomy and authority (Willis,E., 1989) and protected and institutionalised within 'sheltering institutions' that 'support the position of the professions in the political economy' (Freidson, 1986).

Professional power, 'non-structure' and managerialism

In the last two decades it has been argued that professional power has been challenged by economic and managerialist reforms in the health sector, but analysts have, in general terms, refuted any overall decline (Willis, D. 1989; Hafferty & McKinlay, 1993; Willis, 1993 Gabe, Kellehear & Williams, 1994). Analysis at a micro-level however, reveals some outcomes of market-driven health sector reforms that, rather than undermine professional power, may actually increase the potential for its exercise in the form of workplace bullying practices. The move of the professions from 'cottage industry' (Willis, E., 1989; Bates & Linder-Pelz, 1990) to within formal organisational structures has not been accompanied by a breakdown in the interpersonal hierarchy endemic in professional-other interactions. Rather, power and hierarchy has become further entrenched in what has emerged as dual power systems - administrative and professional. The former is highly structured with clear lines of power formalised in bureaucratic management, and the latter a powerful and somewhat amorphous group that could be characterised as 'threatening non-structure' (Douglas, 1988, p123.). The threat inherent in non-structure, where there are no formal lines of authority, is in the informal power systems that emerge. Where there are professionals as partners and/or colleagues in an organisation (such as lawyers, pathologists or radiologists), there is danger for the workers both within and below. Such non-structure creates the potential for the occurrence of workplace bullying within individual hierarchical professional-worker relationships. And when it does occur there is no formal structure or channel for reporting and redress. This situation has not been resolved by the move of these groups to within bureaucratic organisations - particularly with the external imposition of new performance measures (such as 'casemix' in hospitals). Rather, it could be argued extant tensions have been exacerbated.

To use Douglas' analysis of social systems, danger lies at any of four locations within any organisation: at the extreme boundary of the system; in transgressing internal lines; within any of the margins; and from internal contradictions (Douglas, 1988, pp96, 99, 102). These four sites can be examined as danger zones for the abuse of power in organisations and as sites of alienation, victimisation and workplace bullying. The key sites in new managerialist organisation relevant to the present discussion are first, in the occurrence of interstitial or ambiguous roles where individuals - middle managers or workers - are confronted with the conflicting demands of two groups (managers and professionals) who often do not understand each other's purpose.

The second danger zone is located in internal contradictions, where the two groups clash and bystanders can be targeted as scapegoats. The third is in the direct transgression of internal lines where a professional person is appointed to the highest administrative level, such as CEO, whilst continuing professional practice. Here professional power dominates and, in being frustrated by managerialism and managerialist systems, can easily translate into oppressive management practices. And finally, in the exploitation of marginal groups such as trainees and those outsiders who are new to the system, or peripheral labour in the form of part-time, contract and casual staff who are products of the new flexible workforce. It is worth noting that, in systems of non-structure, professionals can and do become the unwitting instrument of workplace bullying practices where their power is appropriated and/or manipulated by others.

Workplace bullying is thus endemic in the culture of organisations where hierarchical relations exist within systems of non-structure, and such systems appear to be resistant to change even, and particularly when, they are brought within bureaucratic control.

Recommendations for policy

The above analysis of the professions and professional training should not be read as criticism of all or even most professional people. Rather, it is intended it provide an understanding of the particular frameworks, pathways and sites within some workplaces that enable individual people to misuse and abuse power. To address the issues raised here requires a tripartite approach that targets three levels: the societal, the workplace culture and the individual.

At the societal level, there is a need to change the discourse that informs our understanding of appropriate behaviours at work to enable new discursive consciousness and practices. This is already happening in Australia with most states introducing either legislation or codes of practice around workplace bullying to ensure that workplaces implement policies and procedures to address the issue. The challenge here is to provide a clear definition that is narrowly focused on those practices directly threatening a person's ability to do their job. This approach will, at a minimum, reduce the instances of people thoughtlessly engaging in or 'buying into' bullying practices, and who are unaware of the consequences of their enjoinment in such behaviours. Training within the workplace will tackle organisational culture that engenders conformity to normative behaviours and thus blindness to the activity of workplace bullying. It will require a degree of re-socialisation in some instances. But most of all, in the very process of naming workplace bullying as a serious threat to mental health and an important occupation health and safety issue, the problem will, in part, begin to be addressed.

At the workplace level, an approach is needed that lays bare workplace bullying practices occurring within hierarchical interpersonal work relationships. If a type of training encourages 'learned helplessness' and passive acceptance of inappropriate criticism of ones' work, then its pedagogical value needs to be questioned. Intense forms of 'on the job' training need close monitoring. Those workplace relationships enshrined in the guise of mentor rather than master-apprentice form remain sacrosanct and immutable unless there is the possibility for intervention. It seems an extension of the multidisciplinary team approach and interdisciplinary interchange (implemented in various areas of diagnosis and treatment), has potential for application in training in a way that could prove beneficial for both the trainee and the mentor. There also needs to be a clear system for reporting abuses of power or experience of victimisation. Where formal structures to enable this do not exist within an organisation, or if the bully is the boss, there needs to be an independent body with power to investigate and take action. Finally, the targeted person has the fundamental right to report instances, of being heard, to be believed and not to face reprisals as a result of speaking out.

At an individual level, it is clear from the above analysis that in most circumstances where hierarchical workplace bullying occurs, that individual counseling and mediation sessions will not adequately address the issue. We need to recognise some people who bully do so in full knowledge of the power they exercise and the knowledge their actions enjoy immunity from scrutiny or reprisal because of their location within the system and because they understand and manipulate the system to their advantage. There is a need for affirmative action that privileges the account of those who have been disempowered and degraded by virtue of simply doing their job. In addition, the individual who has been targeted needs to be encouraged to de-link serial episodes of workplace bullying, for to see them as cumulative inevitably leads to self-blame and recrimination (Namie, 2002).

In conclusion, it is crucial to acknowledge a person has a right to dignity at work and indeed, 'work should not hurt' (Namie, *2002, pers. comm.*). Rather, it should provide an environment conducive to mental health as a minimum standard. An individual should not be subjected to ongoing threats to their health and safety in the closed environment of work, in the course of earning their living.

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10 The impact of workplace violence on third party victims: a mental health perspective

Charmaine Hockley

This paper challenges traditional views about the victims of workplace violence and employer/employee relationships. Since the introduction of occupational health and safety legislation into Australia in the mid-1980s, an organisation's duty of care has been between two parties: the employer and employee. Until recently, workplace violence reports have generally recognised two parties in the relationship - perpetrator and victim. However, it is proposed there is a third party: the witnesses to these behaviours. Discussed here are the results of primary and secondary analyses of research undertaken to study the impact workplace violence has on third parties from a mental health perspective. Early results show workplace violence not only has huge human costs on the primary targets but also on those close to them: colleagues and family members. The outcome is that in some cases consequential tragic circumstances have occurred. Lack of recognition of the seriousness of this phenomenon and the urgent need to provide mental health promotion in the workplace is discussed and strategies for education and publicity are advanced.

Introduction

This paper reports the results of primary and secondary analyses of research undertaken to study the impact that workplace violence has on third parties - colleagues and family members - from a mental health perspective. Secondary analysis data were derived from two studies conducted by Hockley (1999, 2000) into workplace violence and workplace stalking. Primary analysis data were derived from an ongoing study into the impact workplace violence has on family members (Hockley, 2002).

In understanding this ugly phenomenon in the workplace it needs highlighting that current Occupational Health and Safety legislation (OHS) only includes employer/employee relationships. Hence, legislation covers colleagues of the primary target but not family members, even though both groups are third party victims of workplace violence and both groups' mental health and wellbeing are challenged because of their experiences. In the context of the paper reported here, workplace violence is viewed:

> ...as the outcome of any act that causes harm to another person. ... Along a continuum, these acts can range from non-physical, such as abuse of power to physical, including homicide. Violence is not so much the act itself; it is the outcome of a harmful experience. ... harmful experiences may include professional, social, economic, or personal harm, such as loss of career, ostracism, loss of wages, or third party victims experiencing third-party violence (Hockley, 2002a, p5).

Third party violence is an extension of workplace violence and is defined as:

> The outcome of workplace violence which can include those who directly or indirectly witness the event(s) such as those with a professional relationship (eg colleagues), personal relationship (family members) and indirect relationship (eg case managers) (Hockley, 2002b, p71).

It is vitally important all members of the workplace become responsible, in some form, for the mental wellbeing of their employers, workmates and colleagues and, if necessary, to extend that responsibility to include others, such as family members who share the impact of workplace violence. Potential exists for many employers who currently ignore mental health promotion in the workplace to experience how costly and time consuming a mental disorder claim can be compared to a physical injury claim (Moore & Renfrey, 2002). Moore and Renfrey (2002, p110) have shown 'mental disorder claims from 1999/2000 are nearly three times more expensive than non-mental disorder claims (which includes physical injury)'.

Research issues: mental health

Throughout the analysis of my 1999, 2000 and 2002 data reported here, there was no clear delineation between a psychological condition and a mental illness, as one would have anticipated. This was partly because many of the participants described their experiences in mental illness terms, such as 'I felt paranoid', but had never consulted with mental health professionals. Or, they made statements about their low self-esteem, discussed in the literature as being psychological, but again, they had not consulted a psychologist. Thus, these self-assessments were not necessarily clinically validated on all occasions but their stories indicated their mental wellbeing was affected. Mental health is described here as:

> …the embodiment of social, emotional and spiritual wellbeing. It provides individuals with the vitality necessary for active living to achieve goals and to interact with one another in ways that are respectful and just (VicHealth, 1999).

Literature shows many health problems experienced by those who have been bullied at work, such as anxiety, depression, post-traumatic stress disorder (PTSD), stress related skin conditions, suicidal thoughts and suicide (Wilkie, 1996; Hockley, 1999, 2000; Namie, 2002) can also be experienced by colleagues and family members of the targeted person (Hockley, 2002b). The decision about whom to consult for these health problems is determined by many factors. In certain circumstances, primary targets do not have a voluntary choice as to which health professional to consult because to be considered for compensation, they must have a psychiatric report on their mental health status (Moore & Renfrey, 2002). However, family members and colleagues of the targeted person have the mixed freedom of being able to decide to consult, or not consult, which in itself can add to their level of anxiety.

Literature also shows the conditions associated with workplace violence are more closely aligned to psychology than psychiatry (Marais-Steinman, 2002; Rayner, 2002). One possible factor could be that psychologists, such as Heinz Leymann (1990), were the pioneers in researching workplace violence (Rayner, 2002) and therefore became de facto custodians or pioneer parameter-setters. That is, the initial workers in a new area establish the definitions, hierarchies of importance, boundaries of classification, taxonomies, standards of proof and degrees of meaning.

In contrast, mental disorders, defined in practice by either the *Diagnostic and Statistical Manual of Mental Disorders*, (American Psychiatric Association, 2000) or the *International Classification of Diseases: Classification of Mental and Behavioural Disorders* (WHO, 1993), have only recently come into the discourse on workplace violence.

It appears from literature there have been few, if any, studies specifically reporting on the mental harm occurring to third party victims of workplace violence - in particular, the colleagues and family members of the primary target. Hence this study was undertaken to identify the impact of workplace violence on third parties.

Ethnomethodological perspective

The primary and secondary analyses of the data from my three workplace violence studies (1999, 2000, 2002) were guided by ethnomethodological literature, in particular Garfinkel (1967). I also used an ethnomethodological perspective when individually analysing the 1999, 2000 and 2002 studies. Ethnomethodologists are interested in the ways by which people make sense of a situation. When an event occurs that breaches social norms or expectations, thus threatening a person's sense of order and control, ethnomethodologists ask 'What methods would the person use in constructing and maintaining a sense of order?' (Wallace & Wolfe, 1995, p258). An ethnomethodological study is interested in sense-making, and in this context it is used to discover how third party victims make sense of the impact that workplace violence has had on their lives.

Data analysis

Analysis involves primary analysis of data from an ongoing study into the impact of workplace violence on family members (Hockley, 2002) and secondary analysis of data from two earlier studies into workplace violence (Hockley, 1999, 2000). Reusing and reanalysing qualitative data is gaining attention as researchers are becoming increasingly aware of the advantages of such an approach (; Konopásek & Kusá 2000; Thompson, 2000). The advantage of reanalysing earlier data was demonstrated when I reused my 1999 data for the 2000 study into workplace stalking, and again in the 2002 study when comparing colleagues' experiences of mental harm with that of family members' experiences. As family members were the focus of the 2002 study it was appropriate to reuse earlier data where nurses, as the primary target, discussed observing their colleagues being targeted at work. However, in the two earlier studies (Hockley 1999, 2000) the mental health and wellbeing of nurses (either as primary or third party victims) had not been specifically explored and therefore a secondary analysis of the data was undertaken. This approach is in keeping with undertaking secondary analysis as is explained later in this paper. Three types of data were collected for the 1999 study: journalling, interviews and documentation. Data from the 2000 study into workplace stalking were derived from interviews and documentation. The 2002 study also involved a multi-method design, comprising a questionnaire, interviews, and documents (Hockley, 2002). The rationale for undertaking a primary and secondary analysis was to identify the similarities, or differences, between colleagues who were third party workplace victims and family members who were also third party workplace victims. The use of multi-data methods both enhanced validity and enriched the data.

An ethnomethodological method was used to analyse all three data collections (after Garfinkel, 1967). The data were studied for the purposes of description and identification of the 'rules' individuals use to make decisions to ensure their social world maintains a sense of order.

Primary and secondary data were studied in the light of the documentation from my three studies (Hockley, 1999, 2000, 2002). Themes relating to mental health and wellbeing were colour coded and analysed (Baker, 1994). Interpretative analysis is achieved by 'immersion in the data and searching for commonalities and connections' (Baker, 1994, p161). As themes emerged, the body of knowledge was continually increasing and being reinterpreted to gain new insight. This approach follows the documentary method of interpretation (Garfinkel, 1967). Secondary analysis of my 1999 and 2000 data followed the same process as the primary analysis of the 2002 data. Secondary analysis can involve:

> the use of single or multiple qualitative data sets, as well as mixed qualitative and quantitative data sets. In addition, the approach may either be employed by researchers to re-use their own data or by independent analysts using previously established qualitative data sets (Heaton, 1998).

In this instance I employed multiple qualitative data sets (Hockley, 1999, 2000) reusing my own data. This approach addressed some of the issues often raised in the literature (Heaton, 1998; Thorne, 1998). For example, Heaton asks: 'What is the position of the secondary analysis?' and 'Was the analyst part of the original research team?' Heaton (1998) further states:

> This will influence the decision over whether to undertake secondary analysis and, if so, the procedures to be followed. Secondary analysts require access to the original data, including tapes and field notes, in order to re-examine the data with the new focus in mind. This is likely to be easier if they were part of the original research team.

In this instance, I was the original, independent researcher and therefore was able to undertake a secondary analysis without involving or consulting or negotiating with other researchers or analysts (Heaton, 1998). Consent forms were obtained and confidentiality ensured. However, I propose future consent forms should include the participant's permission for secondary analysis to be undertaken (Thompson, 2000). Although analysis has been undertaken of secondary quantitative data (Evers, Ware, Sermeus, Simoens-De Smet & Delesie, 2000; Thompson, 2000), signing a consent form for secondary analysis of qualitative data would be particularly pertinent when sensitive material from victims who have experienced various forms of violence are to be reused.

Participants

Participants in the secondary data (Hockley 1999, 2000) were all female nurses. Participants for the 2002 study comprised primary targets of workplace violence and their family members and there was almost an equal number of males and females and their employment status spanned a variety of work environments from unskilled to skilled labourers, professionals and semi-professionals. A small number of children of the bullied family member responded to the questionnaire. The average family membership comprised two adults and two children.

Findings and discussion

The results show that depending upon the relationship with the primary target, the impact of workplace violence on third parties varies between groups although there may be some overlap. For example, family members, as third party victims, were more likely to suffer financial and health problems than colleagues of the primary target. Colleagues, on the other hand, were more likely to experience professional issues. Both groups of participants experienced social isolation.

One of the reasons why colleagues' financial and health status may be less affected was because they continue to work in paid employment and if necessary, receive counselling assistance from the workplace through Employee Assistance Programs (EAP). Nevertheless, this same group of people may experience professional and social isolation because they may be perceived as being friends of the bullied person and therefore guilty by association. Outcomes may include a lack of promotional opportunity or exclusion from social occasions. Loss of career movement and being ostracised had the potential to affect a person's social, emotional and spiritual wellbeing (Hockley 1999, 2000).

In contrast, family members may initially experience financial difficulties through time lost from employment while caring for the bullied person who is unemployed, in ill health and unable to function either physically or emotionally. At times, family members may also require medical treatment for the parallel stress they are experiencing. In some circumstances, family members have contemplated suicide (Hockley 2002b).

Working with someone who is being bullied

I identified in my study on violence among female nurses (Hockley, 1999) that participants generally discussed third party violence, that is, what they had witnessed, before they discussed their own experiences of being a primary target. There may be several reasons for this. For example, the respondent may feel safer talking about other people's experience of being targeted before they can discuss their own. Conversely, the experience of witnessing a colleague being attacked may have impacted on them more than they realise. The next example is from this 1999 data illustrating a nurse's story of witnessing her colleagues being harassed.

> *There were a group of nurses being harassed. These people got phone calls at home, phone calls in their office, the boss would call and say 'Come and see me in the morning about your job' and of course if someone said that to me I would have had apoplexy. ... but that was the worst example I have seen, in all my nursing that had to be the worst example. It was disgusting. It was a nightmare. [It was] something like out of a book. . There was this awful feeling that the floor underneath you was moving, that it was real slippery and friends were few and far between* (Amelia).

To what extent colleagues are mentally affected by witnessing workplace violence activities is difficult to assess. Nearly all participants in the 1999 and 2000 study could give at least one account of observing a person being bullied at work. Some of these participants discussed leaving their workplace whilst others saw many of their colleagues resign.

The accounts of this group of people generally centred on how many of these behaviours and events went unreported, for some because they did not want to get involved, for others because they thought it was a part of the job, and for others, because of fear of revenge or retribution (Hockley 1999, 2000). All of these reasons have the potential to threaten a person's mental wellbeing.

The following case study is by a university lecturer who believes she is not being affected by her colleague's behaviour.

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Case study

> This story is about 3 lecturers, Amy, Bess & Chloe, who work together in an undergraduate course in a University. Bess believes Chloe bullies her. Amy believes she is 'caught in the middle' because the other two lecturers, Bess & Chloe, each discuss the other person's failings with her. Chloe perceives herself as a good manager. Bess is seeking counselling but has not reported Chloe. Bess has told the counsellor she believes Amy is also being bullied. Amy, who witnesses the interactions between Bess and Chloe, feels uncomfortable Bess is discussing her work relationships with the counsellor. Amy is finding it more and more difficult to avoid these other two lecturers as they all teach in the same course. Amy believes the behaviours of the other two lecturers has not affected her health but believes in the end Bess will need to resign to escape the situation and to maintain her health.

In situations such as the case study above, individuals often do not realise they are being affected until they either leave the environment or find their health is deteriorating, initially with minor ailments such as coughs and colds, headaches, or a general feeling of being unwell. What emerges at times from these experiences is that the colleagues of the bullied person notice changes in their health and emotional status but feel too embarrassed to talk about it and, being in the health profession, are reluctant to visit other health professionals (Hockley 1999, 2000).

A nurse, who had been stalked at work, speaking on behalf of herself and her family, explains one of the contributing factors why health professionals are not consulted. She stated:

> The main reason we did not consult health professionals is this is a small town (when it comes to health industry) and as this happened in the health industry we didn't trust speaking with anyone about what was happening - it could have made things worse for all of us *(Lucina in Hockley 2002 data).*

Living with someone who is being bullied

The 2002 data show living with a person who has been bullied at work can contribute to poor health, changes in financial status and social isolation of that individual. Family members often become the 'sounding board' because at home, conversations appear to be drawn to workplace issues. One family member sums up how she considered living with someone who was bullied at work:

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> *Hell!!!!! Isolating. Draining. Exhausting. Agonising* (Eleanor).

One of the children of a primary target explained her feelings in the following way:

> *Horrible. Hell. Made me feel like I wanted to die. I felt I was to blame* (Ginevra).

Most family members described how prior to these workplace issues impacting on their lives, their marriage, work and family life was perceived as being 'normal'. One respondent sums up family life as:

> *Our life was good with lots of fun.*

In some instances, the mental wellbeing of some family members were already being challenged when they were required to support their spouse who had been bullied at work. A third party victim describes her mental state at the time she was meant to be supporting her husband as follows:

> *I had recently been assaulted. I was unfit for work, suffering post-traumatic disorder severely, with depression, episodes of dissociating, intrusive thoughts about the trauma, hyper-vigilance and anxiety* (Camellia, in Hockley, 2002b).

Supporting her spouse at this time appeared to exacerbate her already precarious mental state, as will be noted later in this discussion.

Family members responses indicated once they had been informed of what was occurring at work, these issues at times 'appeared to take on a life of [their] own' (Hockley, 2002). In some instances colleagues called the primary target at home because they did not want to be seen socialising at work with them. One husband stated:

> *Angelica was on the telephone a lot to others she worked with that had the same problem with the same person.* (Otto).

These interruptions and permanent reminders often made family members angry. For example:

> *I felt she should stand up for herself more and not take the treatment that was being dished out. At times I got angry because I felt I wouldn't let this happen to me* (Medora).

Family members' described how they spent their time supporting the primary target at the risk of either their friends not including them in social activities, or the person who was bullied not wanting to socialise. Family members described how exhausted they became supporting the bullied person, which in the end often took an unexpected toll on their own mental health. Supporting tasks included:

- time is spent on planning strategies
- writing letters
- discussions
- focusing of energies on dealing with the threats to the bullied person's health, work, income, stability etc.
- needing to be careful about what you say, to whom and when
- being aware of management cynicism and duplicity
- being cynical about management statements and intentions/promises
- listening and more listening.

Although family members did not talk about their mental wellbeing *per se* it was obvious from their experiences that their mental health was challenged. The extract below illustrates how both the primary target and the third party victim felt suicidal. One day on her arrival home, the third party victim (Camellia) found her husband in a very distressed state:

> *My witnessing him in this state, and with myself in an emotional mess with my illness was a very crippling experience. ... In the ensuing weeks, with both of us depressed (and on one occasion both feeling suicidal simultaneously), we found it was best for both of us to live separately in the same house, because our depressed states seemed to worsen each other's mood* (Camellia, in Hockley 2002b).

Camellia explains she was not the only person in the house being affected by her husband's experiences. She tells how at times she 'was oblivious' to what was occurring in the household. She reflects upon the impact that third party violence was having on her children:

> *I was oblivious as to how our children were coping at this time, but I would guess that both of our work circumstances would have been perplexing to them and at times worrying. I can remember many occasions where Jed and I were desperately trying to 'brighten ourselves' just before our children returned home from school. With our children witnessing our suffering — physically and mentally — due to the workplace, I often wonder about how their sense of safety and security in the workplace will be in their future careers* (Camellia, in Hockley, 2002b).

Survival skills

Data from my three studies (Hockley 1999, 2000, 2002) showed third party victims of workplace violence chose from four major options. The first option was not to seek assistance from any external resources. The next two options generally began by consulting with a general practitioner (GP) who referred them to either a psychologist or a psychiatrist, depending upon how the victims perceived their problem and specific needs at that time. The fourth option was for them to use a variety of informal processes through a range of community agencies including the church.

Responses from colleagues of the primary target mainly chose the first option and preferred to be self-reliant by providing their own support system. If they did seek professional assistance they consulted a GP or counsellor. Nurses, as third party victims, were generally more likely than family members to seek out alternative therapies including using crystals, aromatherapy, relaxation massages and Reiki. If an organisation had an Employee Assistance Program (EAP) then colleagues generally discussed their problem with a psychologist contracted by the employer (Hockley 1999, 2000).

Although the data showed family members chose all four options, their initial option was to be self-reliant before consulting with a GP, who generally referred them to a psychologist. Although there are many psychological approaches (Smail, 2002) to address workplace violence and the impact it may have on a person's wellbeing, one family member elected to consult with a Jungian psychoanalyst (Hockley, 2002).

The responses showed third party victims used a variety of strategies to survive during this particularly stressful and, at times, devastating period in their lives. Colleagues' survival skills consisted of mainly relying on self, socialising, or resigning from the workplace (Hockley, 1999, 2000). Family members often contemplated separation and divorce, and/or spending more time away from home, for example spending longer hours at work (Hockley, 2002b). Colleagues and family members often resorted to excessive drinking and/or medication abuse as well as using cannabis and heroin (Hockley, 1999, 2002 data). However, for family members it was also a learning experience. For example, they learnt the importance of:

- needing to listen
- maintaining documentation
- negotiation
- understanding power.

Some family members believed they found it helpful to:

- have discussion with their spouse's rehabilitation psychologist
- have meetings with their spouse's lawyer
- meet with their spouse's union representative
- research the topic and have a better understanding of the different types of workplace violence (Hockley 2002 data and Hockley 2002b).

For some, support groups were the best option, while others preferred not to belong to any particular group. Advice for other third party victims of workplace violence included:

- suggesting the primary target move out of the toxic workplace as soon as possible
- not to expect support from management
- using WorkCover
- getting professional help
- going to a gym and working out after a stressful day
- ventilating to people (Hockley 1999, 2000, 2002b and 2002 data).

Promoting mental health in the workplace

Data from the three studies showed there are many opportunities for promoting mental health in the workplace particularly at management level. For example, one respondent during the 2002 data collection phase described how her spouse committed suicide following seven years of workplace bullying and harassment. She reported:

> *The organisations did **nothing** to help even though I was less than 20 minutes drive away, on my own and unable to walk without assistance due to poor health* (Tessira).

This statement highlights the urgent need for raising the awareness of employers on how to manage these situations. Unfortunately, the story is not unique because all the family members in this study, to date, have reported they have not received any assistance from the bullied person's workplace.

The data from the three studies suggest one initiative towards promoting mental health in the workplace is to collaboratively plan and implement immediate to long-term strategies that are evaluated on a regular basis.

Immediate strategies

The organisation needs to inform all staff that any practice adversely affecting the mental well being of an employee will not be tolerated. A consultative approach should be planned to ensure a culture of zero-tolerance is implemented. The following are areas for consideration:

- General policies, procedures and codes of conduct need to be reviewed, developed and implemented reflecting the organisation's philosophy regarding the mental wellbeing of all staff members.
- Specific Mental Health and Employee Assistance Program (EAP) policies that extend to family members are needed.
- Management strategies be planned to minimise misunderstanding such as reviewing management style and its impact on staff.
- Mental health education and training programs should be planned and implemented for all levels of workers including corporate level.
- Education and training programs to include assisting people to recognise signs that can lead to mental health problems and how to develop work and life skills to address these problems, such as assertiveness training, cultural diversity, leadership skills training, and relaxation techniques.
- Identify and manage potential problem areas including physical layout of offices, workplace relationships and workloads that may affect a person's wellbeing.
- Provide assistance to staff who are experiencing antisocial workplace behaviours, such as bullying, which are having an effect on their mental wellbeing.

Mental health practitioners can take a leading role in promoting mental health because it is to everyone's benefit to invest in improving the mental wellbeing of those in the workplace and by extension, their family members. Health and social benefits, such as improved psychological and physical health, healthier workplaces, and higher productivity, can be achieved through an increased and improved understanding of mental wellness.

Long-term strategies

Regular research and evaluation programs should be implemented to ensure workplaces are meeting their goals in not tolerating anti-social workplace behaviours that may affect a person's mental wellbeing. For example, all strategies should be regularly monitored and evaluated against performance indicators, some of which are listed below. Research into the indicators of potential workplace mental harm has a dual role. It provides evidence of current practice and provides a foundation for best practices to be measured. Areas for research include:

- recruiting practices
- staff attrition
- sick leave
- occupational health and safety claims
- Workcover claims
- usage of, and satisfaction with, employee assistance program (EAP)
- community and stakeholders' public image of the organisation
- working relationships within and outside of workplace
- systems for communication and reporting,
- staff satisfaction survey.

Promoting mental health can be advanced at various levels within the workplace including corporate level. Promoting mental health is the responsibility of a wide range of people within and outside the workplace, such as unions and health professionals as well as employers and employees. Mental health practitioners could take the lead in this area by developing, implementing and evaluating workplace mental health programs to reduce the violence some people experience in their workplaces. Community awareness and attitudes towards workplace violence need to be explored and should be high on the public and political agenda.

Evidenced-based education and training services to individuals, community groups, organisations and government agencies to raise awareness of this phenomenon is an important health promotional role.

The stigma attached to mental illness in society has already been recognised (Fuller, Edwards, Procter & Moss, 2002) but when associated with bullying and other emotional health problems, the individual often faces a double disadvantage. Furthermore:

> the impact is often profound, adding to the trauma, and most certainly acting as a barrier to the person and the family being able to seek out and obtain the help and support that they need (Commonwealth Department of Health & Ageing, 2000).

Therefore, mental health promotion in the workplace should be a high priority because the data from my studies (1999, 2000 and 2002) imply there still appears to be a stigma attached to those who are bullied at work. Many experience discrimination from senior management, colleagues and co-workers if they show inability to manage day-to-day work practices because of being bullied or harassed or because of their poor mental health status (Hockley 1999, 2000, 2002).

Family members are often neglected when discussing mental health in workplaces. The responses from my studies (1999, 2000, 2002) show primary targets generally turn to family members rather than colleagues to assist them if they are being bullied at work. Families need preparation for how to provide this support as well as knowing they are not the only ones going through the experience. Therefore, it is also necessary to develop strategies to assist families (or significant others) during this time. As explained earlier, the data show the needs of the family are different to those of the workplace and therefore families require dedicated education and training programs to provide them with support skills - such as listening and communicating, and life skills for their own survival.

Conclusion

The analyses of my three studies (1999, 2000, 2002) provide a disturbing picture of the mental wellbeing of a particular group of people who have been affected by workplace violence, either directly or indirectly.

Results show although colleagues and family members are considered third party victims of workplace violence, the impact on their lives and how they managed their lives were generally different. However, in both groups they experienced anxiety, distress or nervousness, and depression. Some family members even contemplated suicide. The impact on third party victims, particularly family members, identified disruption in their personal, intimate and social relationships. Both groups reported at times an increase in alcohol consumption and/or drug use.

Having a holistic approach to mental health promotion in the workplace is critical as any disruption that damages an individual's ability to interact with workmates, colleagues and managers can have a profound effect on their work status. Although prevention strategies, such as education and training of life and management skills, are vitally important, it is also critical for management to identify and manage workplace violence.

Employers basically have two main choices. Firstly, they can do nothing and potentially experience staff attrition, decreased productivity, increased absenteeism, increased costs for advertising, and employee orientation. There is the potential for whistleblowers to bring the organisation to the attention of the media. It only takes one bullying situation and the business can find itself with a bad reputation, and receiving unfavourable media reports for poor management practices. Or, secondly, management can address workplace violence and the impact it has on third party victims by developing a participative strategic approach to promoting mental health. In taking this second choice, they can be rewarded by providing employees with an environment that allows them to achieve goals and to interact with one another in ways that are respectful, therefore reducing the potential for third party workplace violence victims.

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11 Together we do better: marketing meets mental health promotion and work

Melissa Corkum, VicHealth

The Victorian Health Promotion Foundation (VicHealth) recently launched a mental health promotion campaign, *Together we do better*, to increase community understanding of the importance of obtaining and maintaining mental health. Although not particularly about work or specifically targetting the workplace, elements of the campaign and in particular the links between bullying and health, struck a chord within the community. This paper outlines the development and evolution of VicHealth's *Together we do better* campaign to promote mental health across the community. It also looks at how the campaign has been used by workforces to promote positive mental health.

Background: VicHealth's *Mental Health Promotion Plan*

Three years have passed since VicHealth made promoting mental health and wellbeing one of its top priority areas. Australia's *Mental Health Promotion and Prevention National Action Plan, 1999* clearly showed a significant reduction in the social and economic costs of mental illness will not occur purely with activities and investments that focus on treatment (Commonwealth Department of Health and Aged Care, 1999). This has meant a focus on finding new ways to promote health and wellbeing. The National Action Plan challenged 'everyone within and across all sectors to provide quality services, programs and initiatives that involve a spectrum of interventions to reduce mental health disorders and problems and to improve wellbeing' (Commonwealth Department of Health and Aged Care, 1999,p4).

VicHealth set about meeting this challenge with the development and implementation of the *Mental Health Promotion Plan* that aimed to create, facilitate, and develop partnerships across sectors — with sport and recreation, transport, education, built environment, local government, workplace, the arts, and culture. The Plan was formed in consultation with over 100 organisations to develop a mental health promotion framework and to identify areas for action. Three key determinants of mental health featured significantly in the research: social connectedness, freedom from discrimination, and economic participation (VicHealth, 1999). VicHealth's mental health promotion framework focuses on these three determinants.

The challenge for us all – as practitioners across sectors, policy makers and advocates – is to find new ways to promote good mental health. This is a big challenge. Although VicHealth made mental health promotion a top priority for three years, it is recognised that bringing about such monumental social changes will be a long-term process; it's more like a thirty-year plan.

How do we bring about such changes? One step at a time; change will not take place overnight. VicHealth made a long-term commitment to start increasing mental health literacy and understanding within the community; to ensuring that services within the community are accessible and appropriate, and that environments are safe. Change is also about building the capacities of organisations and communities and individuals to promote mental health (VicHealth, 1999). This idea is particularly relevant to the workplace. It means changing environments so they improve the health of the general population and strengthening people's understanding and skills to achieve and maintain wellbeing. Within organisations and workplaces, it is helping to establish healthy policies and programs and building partnerships to ensure sustainable change.

But a complete change will not occur during the three-year life of the *Mental Health Promotion Plan*. Although VicHealth's plan extends until 2002, mental health promotion is a long-term investment. Such changes require a multi-faceted and integrated approach. VicHealth's Mental Health Promotion framework includes research, workforce education and skill development, direct service pilots, community strengthening, organisational and individual capacity building, advocacy for legislative and policy reform, communications and marketing, and evaluation (VicHealth, 1999).

Such broad-based projects illustrate the breadth and diversity of areas encompassed by the Plan. It is hoped the projects funded under the Plan provide successful models of practice, which can be transferred and integrated by a number of diverse communities across the state. It is especially hoped outcomes of these projects will have implications for policy and legislation.

Marketing and communications: part of the Plan

The Plan aims to increase awareness by the general public about the importance of mental health promotion and to advocate for the development of innovative partnerships and strategies. A comprehensive communications approach was developed to contribute to both social change and individual behaviour change.

The Mental Health Promotion Framework identifies communications as one of the health promotion actions to address the three themes for action: social connectedness, freedom from discrimination, and economic participation (VicHealth, 1999). The Plan commits VicHealth to a range of initiatives to support the implementation of activities. Advocacy and communications are employed to ensure mental health promotion initiatives are undertaken at a community level, organisational level and all three levels of government (VicHealth, 1999). VicHealth's commitment to agenda setting and advocacy for policy and practice development, both locally and globally, is a driving force behind its mental health promotion initiative. A mass media campaign was developed to support VicHealth's policy and community level initiatives. It was also developed to visibly demonstrate its commitment to mental health by encouraging attitudes and reinforcing behaviours that value and facilitate social connectedness among individuals and organisations.

Advocacy and communications are key tools for promoting healthy policies and increasing community resources for building healthier communities. Importantly, these tools support other strategies within VicHealth's mental health promotion framework including education and training, organisational development, empowering communities and research. The combination helps ensure a comprehensive approach to this issue.

Advocacy for legislative and policy reform and communications/social marketing are identified in the *Mental Health Promotion Plan* as necessary health actions. Communications and advocacy also play a key support role to other essential aspects of VicHealth's approach to Mental Health Promotion as captured in many of the funded projects. These aspects include direct services, education and training, organisational development, empowering communities and research (VicHealth, 1999). The communications strategy is therefore comprehensive and multi-facetted. In an operational sense the strategy works in four parts:

1. Supporting and promoting funded projects.
2. Increasing awareness and changing attitudes and behaviour.
3. Advocating for social change.
4. Networking for sustainability.

To be effective, communication strategies designed to influence community understanding, and ultimately behaviour, need to work across several different levels. Achieving change is contingent on change at a community, structural and environmental level. It must therefore be meaningful for individuals who make up the community as a whole. With this in mind, the focus of VicHealth's communications strategy was *both* community and mass media focused.

Together we do better

After an extensive research process, which included testing and refining, the *Together we do better* campaign was developed to put a modern face to existing and commonly held beliefs - to contemporise and validate them. It revalues the importance of supportive relationships; provides new information to back up beliefs, validates the need for change; and models practical, achievable behaviours that have functional benefits. These themes stem directly from VicHealth's *Mental Health Promotion Plan*.

On June 12, 2001, VicHealth together with John Landy, Governor of Victoria, launched *Together we do better* to visibly demonstrate its commitment to mental health and to increase community understanding of the importance of obtaining and maintaining mental health. The campaign was developed to get people thinking about the personal and community benefits of social connection, to develop more tolerant and accepting attitudes, and to encourage understanding of the link between mental and physical health. More importantly, the campaign was designed to reinforce the idea that *together we do better* as individuals and as a community.

The campaign communicates the fact that participation and belonging are vital to the health and wellbeing of all individuals and increasing awareness of the importance of issues such as tolerance, inclusion, diversity and belonging. And this goes across communities, sporting organisations, arts organisations, religious groups, schools and work. Though VicHealth's Plan identified five priority groups, the *Together we do better* campaign is broad based – for the general population. This decision was based on the notion that mental health is for everyone and affects us all.

In the beginning, the first flight of campaign activity featured a series of three print advertisements and six radio announcements. All the ads reinforced the message 'together we do better' and focused on the importance of social connection.

Together we do better print ads

An essential crisis management tool
A nice big teapot and two cups. It is ready for drinking. Just what's needed to interrupt a chaotic or stressful moment or to share with a friend or colleague. The teapot symbolises a time without stress or conflict.

A fast track to success
A man is reading a bedtime story to his son. The rush of the day is over and both father and son are enjoying the story and their time together. The little boy looks secure. Dad looks content. The copy explores the benefits of close family ties for both children and parents.

Open heart surgery
A gothic looking young woman is talking with an older woman. These two unlikely companions are clearly enjoying one another's company. The copy explores the health benefits of open-heartedness and connecting with people around you.

Both the print and radio announcements touch on social attitudes people would like to experience – including respect, acceptance and belonging (VicHealth, 2001b). The radio ads are stories of real people. One particular radio ad struck a chord with members of the public and helped shape the future directions of the campaign. 'The lads and the lesbian' radio ad reflects the attitudes and actions of an employer who must act to address harassment of a female employee by other male employees.

> We had a young lesbian lady at work and we had to make really sure that the fellas knew exactly where they stood in relation to the law because they were – you know – taking liberties – harassing that young lady. She stood her ground but that didn't help. They had a lot of trouble letting it alone. I don't know how much it bothered them – they were mainly entertaining themselves. It's not on! Besides it's illegal. But I don't think they could see the harm in it.

The ad goes on to identify the link between bullying, harassment, and stress and serious mental and physical illness.

Campaign activity included paid advertising in newspapers, radio, trams and cinema. This was supported by unpaid public relations activities, posters, postcards, partner packs, brochures, speaking opportunities and the establishment of an email-based mental health promotion network.

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Partner packs were distributed to give organisations and individuals a range of ideas and information for promoting the campaign messages and what they are doing in ways relevant to their own circumstances. A range of organisations requested the materials. As expected, interest was high among health organisations, schools and community groups; workplaces were also interested in the positive messages the campaign offered. The *Essential Crisis Management Tool* in particular had a universal appeal, and was requested by many workplaces. An article relating to the campaign and the importance of promoting good mental health in the workplace was published in an issue of the Victorian Employers' Chamber of Commerce and Industry (VECCI) *Business Forum*, which is distributed directly to 10,000 businesses and decision-makers (VECCI, 2002). This was of special relevance to work and workforce issues.

It is noteworthy that many organisations working in health and community areas were interested in the materials for the use of their constituents, clients or community members; they were also interested in them for use in their own workplace. Recipients reported the materials were often used as discussion starters.

A benchmark study of community attitudes towards health and wellbeing was undertaken prior to the launch of the campaign to establish Victorians' beliefs in relation to health (physical and emotional) and wellbeing. Smaller tracking surveys were completed just after each flight of campaign advertising to assess the success of the first phase of the campaign. Comparisons are made to the benchmark to examine any changes that have occurred in public awareness, understanding and attitudes since the benchmark survey was conducted. Findings after flight one of activity showed:

- Nearly one in five Victorians claimed awareness of the 'Together we do better' slogan
- One in twenty Victorians took action as a result of the campaign
- The link between social activity and health is understood and accepted
- The link between emotional health and overall wellbeing is not as clear, and
- Victorians respond more positively to concepts that clearly demonstrate benefits to them (VicHealth, 2001c).

Evolution of the bully

Feedback received from the *Lads and lesbian* radio ad related to how bullying, discrimination, exclusion have an impact on wellbeing (although the initial concept did not specifically focus on bullying, it was one of the underlying themes). The overall campaign was developed to increase community understanding of the importance of obtaining and maintaining mental health and to increase awareness of the importance of issues such as tolerance, inclusion, diversity and belonging. The obvious bullying theme of the *Lads and the lesbian* ad struck a definitive chord within the community from a range of areas. Feedback came from people who had been bullied, parents whose children had been bullied, workplaces, and schools in particular. The range and volume of feedback sits with broader evidence of the prevalence of bullying within the community as a whole.

The Queensland Government's Department of Industrial Relations has recently released findings of a taskforce on workplace bullying. According to the report, empirical studies estimate that nationally between 400,000 and 2 million Australians will be harassed at work in any one year, and between 2.5 million and 5 million Australians at some point during their careers (Queensland Government Department of Industrial Relations, March 2002). The same report highlighted the cost of workplace harassment to industry is estimated at between $6 to $13 billion a year, thus representing between 0.9% and 2% of Gross Domestic Product (Queensland Government Department of Industrial Relations, March 2002).

Feedback on the theme of bullying was quite significant during flight one. From there it was decided this would be a focus of a concept for further flights of campaign activity.

Developing partnerships with different sectors, settings, organisations and community groups is a key plank in the mental health promotion strategy. It is important to bring together the combined expertise of others and also means increased potential for the long-term sustainability of the work. This was particularly crucial in the area of bullying. Being out in the public arena, promoting the health impacts of bullying meant raising the profile of the issue even further. People want to know where to go, who they could talk to and where they could turn for help. As VicHealth is not a service provider, it was important to develop alliances with organisations working in this area. A strong partnership base also meant more organisations could respond and contribute to public discussion.

To support flight two of activity, a community-attitudes survey was commissioned by VicHealth to assess and gain insight into Victorian attitudes towards bullying and bullies. The research assessed the community's notion of bullying; explored current perceptions of bullying, who bullies and where bullying occurs, opinions of the relationship of bullying and discrimination; and provided information that could be used to support new messages and generate publicity for flight two of the campaign.

The survey of 600 Victorians aged between 18 and 65 identified bullying as being rife across society, from the more traditionally known settings for bullying – schools and workplaces – to government, media and sporting circles. Results included:

- Two thirds of Victorians believe we have a culture of bullying
- 91% of those surveyed had been a victim of one or more bullying behaviours identified in the study
- 95% said bullying was never acceptable and only 8% believed the prevalent culture of bullying should be acceptable
- Seven out of 10 Victorians surveyed believed racial abuse on the sports field was bullying and 6 in 10 thought 'sledging' (constantly digging at an opponent) or using intimidating tactics on the sports field were also acts of bullying
- 10% of Victorians had been on the receiving end of 'sledging'. As was the case in other sport-related bullying behaviours, males are more likely to accept it as part of the game, with 45% considering sledging bullying behaviour compared with 67% of females
- Another 15% reported they'd been the victim of intimidation on the sportsfield, with females again more likely to consider these tactics to be bullying (71% compared to 50% of males)
- when asked to name a public personality who was a bully, 6% nominated a sporting identify (VicHealth 2001b).

A new bullying ad - *Do we ever get over it?* - was developed, linking bullying behaviours to health.

The bullying ad

Do We Ever Get Over It?
Did you know that a bully does life-long damage? It's a fact. Cruelty seeps deep into us and is seldom forgotten. It can often lead to depression and addiction and illness. So it's a healthy challenge to notice our own small acts of unkindness and to speak up when we see anyone pushed into a corner.

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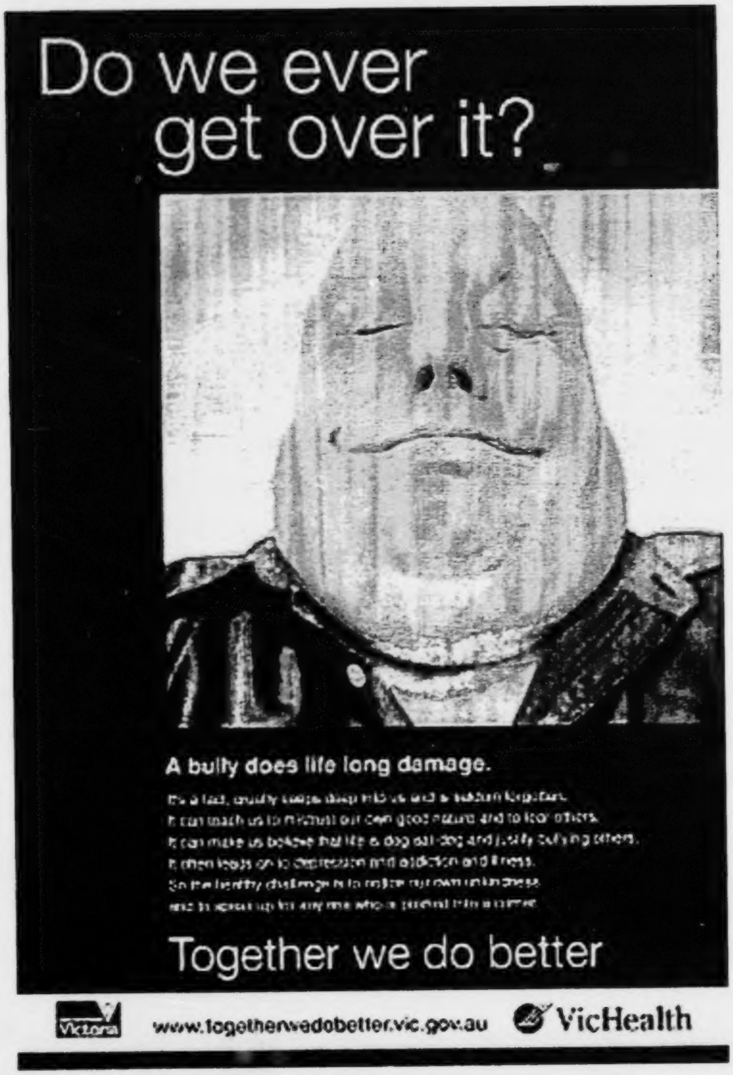

Do we ever
get over it?

A bully does life long damage.

It's a fact, cruelty seeps deep into us and is seldom forgotten.
It can teach us to mistrust our own good nature and to fear others.
It can make us believe that life is dog eat dog and justify bullying others.
It often leads on to depression and addiction and illness.
So the healthy challenge is to notice our own unkindness
and to speak up for anyone who is pushed into a corner.

Together we do better

Victoria www.togetherwedobetter.vic.gov.au VicHealth

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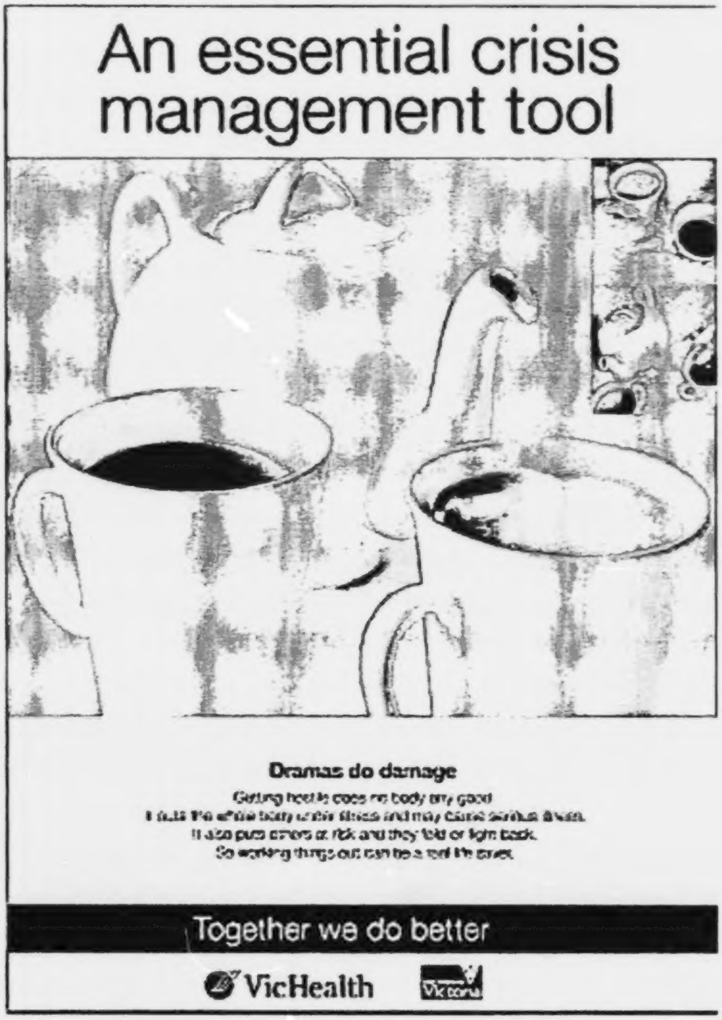

An essential crisis management tool

Dramas do damage

Together we do better

VicHealth

Again the bullying issue continued to strike a chord across the community. People either liked or expressed discontent and discomfort over the ad. Whether or not people liked the ad and the image in the ad, what it was doing was generating discussion about bullying behaviour. Findings after flight two of campaign activity which ran from September 20, 2001 showed that:

- One in 10 Victorians recalled ads referring to the campaign
- Majority say they evoked positive thoughts to ads
- Understanding of 'together we do better' message — relating to tolerance, acceptance — jumped from 3% (Wave 1) to 10%
- Prompted recognition of ads that say being friendly, helping others & community involvement can lead to improved health was 19%
- Prompted recognition of 'together we do better' 18% for all respondents; and
- Six in 10 Victorians who have seen the campaign have taken positive action as a result (VicHealth 2001d).

Tied to the communications strategy is the commitment to advocacy for legislative and policy reform. When WorkSafe Victoria announced its draft code of practice for the prevention of bullying and violence in the workplace, VicHealth could then provide comment about the health implications of bullying behaviour in the workplace.

In February 2002, VicHealth launched more of *Together we do better*, this time with more emphasis on bullying behaviour across the community. Although it was specifically launched during the 'back to school' period, it was recognised the school is a microcosm of the broader community. School is one setting where bullying can occur. It is also recognised bullying at school isn't just about the bullying behaviours of students; school is also a workplace.

Building strong partnerships was an important element of campaign activity. As the campaign was being re-launched during back to school week, the diverse number of organisations working in this area was recognised. There are many organisations tackling bullying behaviour in schools, through a whole of school approach and within the community. VicHealth joined forces with the Department of Education, Employment and Training (Social Competencies Unit), Kids Help Line, the Centre for Adolescent Health, The Alannah and Madeline Foundation and Mind Matters, to advocate that doing nothing is not an option and to provide much-needed information about the long-term health consequences of bullying behaviour. It was important to highlight what parents can expect from schools, what schools are doing to prevent and lower the risk of bullying behaviour, useful tips for dealing with bullying behaviour, available resources, and also to highlight that bullying is everybody's responsibility. Results of the follow-up tracking survey of 600 Victorians show that:

- Nearly half of Victorians (45%) recalled seeing advertising carrying one or both of the themes featured in the campaign (bullying and/or social connection)
- The bullying theme had the greatest recall with one in three Victorians having seen or heard ads relating to this (VicHealth, April 2002).

Overall feedback for the first phase of campaign activity, which was spread out over a 10-month period in both metro and regional Victoria, was extremely positive. In particular, the campaign has been useful in terms of generating discussion and debate around issues relating to mental health within and across the community. The task ahead is to determine what the future focus *Together we do better* should take.

Conclusion

Although VicHealth's *Together we do better* campaign to promote mental health was developed to be broad based and specifically for the general community, work and the general community are not mutually exclusive. Evidence suggests elements of the campaign were particularly relevant and useful within workplaces across Victoria.

Ultimately most of us want to participate, to belong and be part of something. And this includes our workplace, our local street network, community, club, school or workplace. Work is a place where people can connect with others and achieve a sense of belonging. The *Together we do better* campaign is about being healthy and well physically, mentally, emotionally and socially. This involves workplaces, schools, families, sports, arts as well as the community.

For more information about the *Together we do better* campaign please contact Melissa Corkum, Public Relations Coordinator, VicHealth, on 03 9667 1319 or *mcorkum@vichealth.vic.gov.au*
Information is also available at <www.togetherwedobetter.vic.gov.au>

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12 Consumer perspective employment in the psychiatric service system: a Victorian view on safety issues

Cath Roper

Opportunities for consumers to explore our employment within the psychiatric service system are urgently needed. This article raises issues and dilemmas concerning un/safety and consumer perspective employment, for ongoing debate and discussion. I identify as a psychiatric service receiver and use the word 'we' generally to refer only to consumers, not to 'people in general'. The word 'consumer' as described here refers someone who has received a psychiatric service. The Mental Health Statement of Rights and Responsibilities defines *consumer* as:

A person making use of, or being significantly affected by a mental health service (Australian Health Ministers, 1991, p16).

Consumer perspective employment as opposed to 'participation'

'Consumer participation' historically confuses paid consumer consultancy with being a 'well' role model for 'sicker' consumers, or with being a 'representative' of *all consumers*. Or, to give another example, it confuses consumer perspective delivery of training to mental health practitioners with the idea that we must, by definition, need training ourselves in order to participate in this 'very complicated' mental health system. I will draw a distinction between what is currently termed 'consumer participation' and what I call *consumer perspective paid employment in the psychiatric service system*.

This article concentrates only on those of us who are employed *precisely because of* our consumer experience, and who are essentially *trading* our consumer perspective and are employed for that purpose. Consumer consultancy within Mental Health Services is now the prime manifestation of consumer perspective paid employment.

It is noted there are consumers occupying other roles within the mental health service system, for example as support workers in the non-government sector who are not necessarily employed solely for their consumer perspective. As well, there are those who have had experience of mental health service usage, but who are not 'speaking out' about those experiences.

Another application of 'consumer perspective paid employment' briefly examined here, is the provision of consumer perspective training and education to mental health practitioners. Both consumer consultants and independent consumer perspective workers have engaged in this form of work, directly and indirectly, for years. Here, I focus specifically on the role I currently occupy at the Centre for Psychiatric Nursing Research and Practice within the University of Melbourne as Consumer Academic. Although this role is an example of work that may be part of a 'search for healing' that does not *endanger* us, it still reveals challenges about consumer perspective worker safety.

Paid work roles for self-identified consumer employees – the service system meets the consumer consultant role

The Victorian Mental Illness Awareness Council (VMIAC), the peak consumer body in Victoria, commissioned the work later known as the 'Understanding and Involvement' (U&I) project (Epstein & Wadsworth, 1994) and its antecedents (McGuiness & Wadsworth, 1991; McCarthy & Salvage, 1993). The project ultimately presented a 'model' for both the creation and carrying out of consumer consultancy in clinical settings and produced a handbook for staff-consumer consultants (Wadsworth & Epstein, 1996).

In late 1996, the first four consumer consultants in Victoria were employed at the Royal Melbourne Hospital. Having consumers working in clinical settings, traditionally the place for consumer as sick person only, was a critical turning point in manifesting a concept of consumer participation. The U&I project placed emphasis on dialogue, and used a participatory action research model in its design, to which consultants were introduced. Theoretically at least, attention was paid to the importance of consumers acting as consultants to staff as well as to consumers, hence the initial name, staff-consumer consultant. Acute units or wards were recognised as busy places not easily lending themselves to reflective practice, so structures to facilitate ongoing interest and support through the early developmental years of the research preceding the 'model', were crucial and these were maintained as the four consultants began carrying out their role.

At this time, Victoria was in the throes of some of the most major reforms ever undertaken in the mental health service system. The demise of the stand-alone facility, co-location with urban general hospitals, radical disposal of thousands of inpatient beds, shorter inpatient stays, the birth of health networks and concomitant devolution of management to these structures – the effects of all these reforms were just starting to be felt.

Armed as we were with quite sophisticated approaches to working collaboratively with staff, we found, not surprisingly, that staff had trouble figuring out how to use our role, found us a difficult presence, and had no real desire (in some ways, understandably) to deal with the problems articulated by consumers – on top of all of the other radical service system changes they had to contend with. If, for example, we wished to raise the issue of people not having anything meaningful to do, to whom did we raise it? How was it then followed up? How did we make sure there was action taken? How did we report back to consumers? How did we do all this in four hours twice a week? There were in fact no local structures built into the workplace itself for our roles to be negotiated with management and staff, or to keep momentum of the new role going.

In the orientation provided to us prior to our employment as staff-consumer consultants, we were urged to be 'more professional than the professionals' (Wadsworth & Epstein, 1996, p43) and 'learn the ways' of the organization in order to participate in it. We didn't question the idea that consumers needed to be trained in the art of conducting meetings, minute taking, behaving correctly, and understanding, for example, the 'very complex concepts and language' of the medical model, quality improvement, clinical and management practices and their rationale. Beliefs of this kind though, have acted as exclusionary factors when it comes to applying for, and being seen as 'successful' applicants for consumer consultant positions. Instead of our unique perspective being valued for the wisdom it contains, born out of our experience of disability, whether or not the disability affects us 'in the now', we often felt obliged to disown it. And in so doing, disown the very foundation upon which rests our unique perspective and which connects us to those service users with whom we work.

Within a year of the introduction of the first staff-consumer consultants, the Department of Human Services provided what was to become recurrent funding for the statewide introduction of similar roles for every Area Mental Health Service.

Un/safety and the consumer consultant role: issues and dilemmas

Being told: 'You are just the same as any employee', sounds good, sounds egalitarian, but in fact, we aren't the same. A consumer who works in the clinical setting is not providing a service in the traditional sense. Further, we do not yet have enough experience of safety or access to decision-making to have experimented with what we might need and hence begin to articulate those needs. If we think learning the language of the psychiatric service system is the secret to our being taken seriously, then we are in danger.

It is the responsibility of any organisation we work in to provide the conditions we need in order to do our job (Findlay, 2000). Instead, organizations initiated discussions with consumer workers about de facto contracts regarding what to do when they 'got sick' or if the consumer consultant 'needed support' - and discussions about which staff member might provide that support.

While the U&I model stressed the need for consultants to work in pairs, primarily as a measure to strengthen consumer perspective and keep the workers safe, in many cases, consultants were 'split up' to 'cover more ground', or even employed as solo consultants. There was no imperative for organisations to make the sorts of changes to their traditional way of doing things, that would enable consumers to use their creativity in order to work within them, or influence attitudes of staff.

Quality improvement framework

The U&I model positioned consumer consultancy within the framework of quality improvement. Yet, if we were employed to improve the quality of services, how did we speak about the disappearing act of all those hospital beds, of all those people we knew about who couldn't access hospital when they deemed it necessary? How did we speak about quality, if we weren't allowed to define what quality was? How did we speak about quality if all we knew was what we had been offered to date – especially if it was at odds with clinical opinion? How did we speak about consumer experience that was outside the framework of 'quality' and just plain 'not good enough' or in the worst cases, inhumane? How could we legitimately be the activists we were, without being told to 'watch what we say, and to whom' or have our efforts disregarded either overtly or covertly. Although the U&I model stressed systemic, not individual, advocacy, how could that really be played out?

If the emphasis and responsibility for occupational health and safety is not placed squarely back on the organisation, the consumer can feel an unbearable sense of personal failure, not just within the context of their employment, but at the level of their personhood. The issues that impel one to become an activist are inseparable from one's self. In fact, the vital mechanisms that would best support consumers have been largely left up to those individual services to decide upon, not given to consumers to work out, and rarely have they been addressed to the consumer workers' satisfaction.

Some things learned through teaching

Many of the observations already made here about our un/safety in working as employees of clinical services also apply to a more removed role – teaching post-graduate psychiatric nursing students in a higher education setting. There is isolation in being the sole provider of a minority perspective. In teaching what is not welcome, exposing difficult 'truths', or questioning clinical discourse, the 'teacher' runs the risk of unwittingly internalising any discomfort engendered in others. Further, nursing students, rather than engaging with this perspective, might resent and so ignore it, regarding it as an intolerable intrusion on the 'real' learning that has to be achieved in an extremely demanding year – how to conduct interviews, make assessments, diagnose and treat 'mental illness'. Yet part of the freedom of the role lies in being able to articulate such issues, think about them, talk about them and write about them.

The consumer academic role within the Centre for Psychiatric Nursing Research and Practice has allowed me to find my own working pace, to think and act for myself, to create varied ways to do consumer perspective work that are original, supported, and more safe than in constrained clinical settings. It is understood the role must be enhanced by a variety of other paid consumer perspective input, and the project team supporting the role has a majority consumer presence.

During the last decade, many resources, campaigns, consultations, committees and projects have been developed through Australia's National Mental Health Strategy. But very few resources are ever given directly to consumers, for example, to be used to create the kinds of vital infrastructure we need in order to be able to participate more safely. If we had a fully resourced 'place of our own' then I believe we might start to purchase the safety we require and are owed. We would be well placed to share and articulate our experiences about safety and un/safety – decide how best to manage these issues for ourselves. We would have a place from which to launch projects, be contracted for our consumer perspective services – whether in training, or developing consumer provider services, or tendering for government projects, or providing an alternative to, and support for, those engaged in service based consultancy.

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Section IV
Work and emotions

This section on work and emotions begins poignantly with another Peter Waterhouse poem, *Blue Roses of Collingwood*, hinting at the pain of the collapse of factory work in Australia and the implications for migrant women workers. We were not surprised to receive several papers on the relationship between work, emotional labour and mental wellbeing. In the last two decades the pioneering work of Arlie Hochschild has been taken up by a number of researchers in their examination of the service and caring professions (Hochschild 1983; James 1989; Small 1996). What did surprise us was the way researchers from a variety of disciplines were using Hochschild's insights to confirm her initial claims and their own observations.

The concept of emotional labour is integral to service work and the caring professions. It does not refer to the expression of negative or positive emotions that may be part of pleasant interactions between work colleagues, or the bullying or the fear of redundancies outlined in the previous section. Emotional labour refers to the fact that in some occupations and professions emotions form a central part of the worker's skills. Without this emotional labour the quality of the service would diminish and in some cases be impossible to perform. As a consequence, it is part of what is purchased when the employer hires a worker. The classic example is the profession of nursing where competence is defined in terms of an orientation to service coupled with a high degree of clinical competence along with good interpersonal skills. It is these good interpersonal skills that enable the nurse to perform unpleasant tasks on the body of the patient without apparent distaste. It is not that the nurse acts on the surface, but at a very deep level she or he has transformed the self so that these difficult tasks can be performed with genuineness. Hochschild suggested that as a consequence, emotions risk becoming commodified. This is particularly so where workers are required to use them over extended periods, without support, or in ways that run counter to normal human and mentally healthy responses. Two papers in this section by Vanda Lucia Zammuner, Lorella Lotto and Cristina Galli, and Sue Stack explore this jeopardy.

Both Zammuner *et al.* and Stack explore the use of emotions in service work, specifically health care. What intrigued us initially were the theoretical similarities in these papers, yet the differing approaches, one drawing on psychology, the other taking a sociological approach. Despite the discipline differences, the conclusions are similar. Zammuner *et al.* and Stack outline the ways in which health professionals – care workers, nurses and doctors – must use their emotions in the service of others. In many contemporary workplaces that are victim to staff cuts or where the pace of work accelerates, these service workers risk having their emotional labour appropriated by managers and owners in the interest of profit or efficiency. It is in this domain that we find the ingredients for mental illness, but also insights into what makes for a mentally healthy workplace. The results reached by Zammuner *et al.* show clearly that service workers must be given adequate time to perform emotional labour and that the demands made on the worker must be cognisant with the situation. Where this is not so, burnout and alienation may result. Similarly, Stack illustrates that care workers, whether they be registered nurses or untrained assistants, need adequate time, flexibility and educational preparation to care for their clients. Workplaces that provide these elements are mentally healthy workplaces.

The third and fourth papers in this section illustrate the centrality of emotions in working life. Monica Leon points to the importance of emotions for survival, while Peter Hosie, Nick Forster and Peter Sevastos indicate the value of positive affect in productivity and wellbeing. Leon outlines the parameters of fear and anxiety, arguing that while unpleasant, these emotions are not necessarily counter-productive in the workplace. They are emotions that are part of the ordinary, everyday life of being human. What is illness-provoking is situations where they predominate and the worker finds themselves in a near permanent state of alert. We found her term 'toxic handlers' useful for explaining some of the ill health effects on managers and other responsible people in organisations, particularly those caught between decision-makers and workers. This particular analysis sits neatly with Peter Hosie and his colleagues' exploration of managers' affective states. Their paper is not a study of the use of emotions in the workplace, but a study of the impact of emotional states on capability and performance. Much of the discussion is a prelude to asking difficult questions about the relationship between mental health promotion and the bottom line – i.e. continued healthy profits for workers, company executives, managers and shareholders. Despite this we would not want to gloss over some of the apparent contradictions, particularly the authors' findings that the 'new enterprise formula of '1/2 x 2 x 3'– whereby half as many people are being paid twice as much, to produce three times more (Handy 1995, p3) – is now the norm. We think it gives some clue to understanding current ill ease in the workplace. That Handy considered this formula 'about right' is evidence of widespread work intensification. Where it is the norm, it gives a clue to the nature of emotional exhaustion, burnout and the diminished sense of personal accomplishment experienced by some people in their workplace. It cannot be a universal formula for wellbeing. New ways of profit-making must be found that bring both managers and workers into a satisfying and health-promoting partnership.

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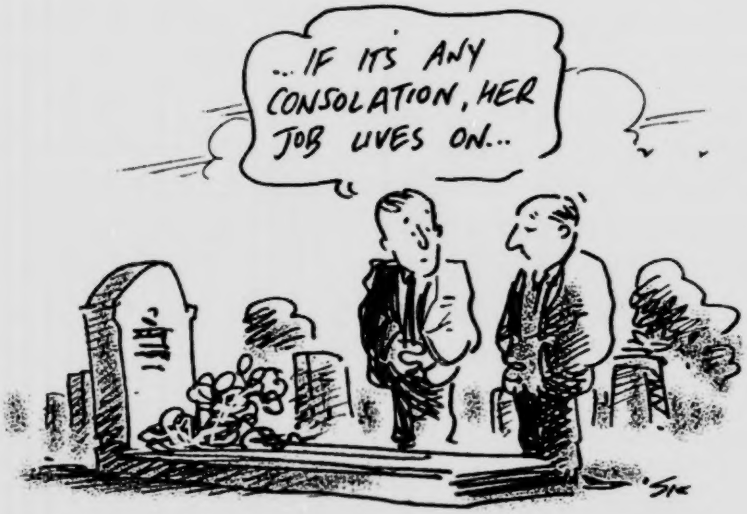
...IF IT'S ANY CONSOLATION, HER JOB LIVES ON...

Blue Roses of Collingwood

(for Barry)
Barry works in a laboratory in Collingwood.
It probably used to be a textile factory, our building,
but they refurbished it. He explained,
It's a private company,
doing mostly genetic engineering.
They're trying to make blue roses.

I imagine white coats, sterile glass and stainless steel
where there was once the rattle and whirr
of a thousand bobbins.
I see the faces of many migrant women
labouring in rows;
fabric fed into the invisible blur of moving needles
is suddenly fastened onto flesh,
stitched through the webbing between the fingers.
There is swearing and crying
in many tongues, and tears,
and a foreman complaining
of blood on the stock and lost time.

Generations of workers have persevered
in Carringbush conditions – they do so still –
sweating in sultry summers,
aching and weary in winter chills.
They persist for the promise of a better life,
or perhaps because this is a better life
than the front row seats in the 'theatres of war'
from which they came.

But do they, in their wildest dreams,
imagine the quiet hum of air conditioning
providing climatic control for computers and plant stock
and a new generation of workers,
with microscopes and test tubes,
striving to create, for the crystal vases of Toorak,
the rare Blue Roses of Collingwood.

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13 Job-related affective wellbeing and intrinsic job satisfaction related to managers' performance

Peter Hosie, Nick Forster and Peter Sevastos

This paper reports on a study of the 'happy-productive worker' thesis – the impact of job-related affective wellbeing and intrinsic job satisfaction on managers' performance. Decades of research have been unable to establish a strong link between intrinsic job satisfaction and performance. Despite mixed empirical evidence, there is some support to suggest a relationship exists between affective wellbeing, intrinsic job satisfaction and managers' performance. The goal of the research was to establish which indicators of managers' affective wellbeing and intrinsic job satisfaction predict dimensions of their contextual and task performance. Affect has rarely been used as a predictor of managers' job performance outcomes. Managers' self-report of affective wellbeing and intrinsic job satisfaction were assessed in term of superiors' ratings of managers' performance and related to ensure independence of the measures.

An instrument was developed to measure the structure of managers' contextual and task performance. An eight-dimensional measurement model of managers' performance, derived from the survey data, was tested by exploratory and confirmatory factor analysis to differentiate the structure of managers' contextual and task performance. The performance construct was operationalised in terms of four contextual dimensions (***Endorsing, Helping, Persisting, Following***) and four task dimensions (***Monitoring, Technical, Influencing, Delegating***). These dimensions were confirmed through multi-sample analysis and cross-validation techniques of managers' and superiors' ratings. Canonical correlation and standard multiple regression were used to analyse the linear combination of managers' affective wellbeing and intrinsic job satisfaction with contextual and task performance. Indicators of affective wellbeing and intrinsic job satisfaction were found to predict dimensions of managers' performance, irrespective of whether the performance scores were from self-report or supervisor-ratings.

Introduction

In this study of the 'happy-productive worker' thesis, key theoretical developments were integrated from the substantial literature to provide linkages between the conceptual bases of the constructs of affective wellbeing, intrinsic job satisfaction and managers' performance. Evidence has emerged suggesting managers' job performance comprises both contextual and task performance domains.

Western societies are increasingly aware of the incidence of psychological disorders in the workplace (Levi, 1990; Millar, 1990; Ganster & Schaubroeck, 1991), prompting occupational and organisational psychologists to scrutinise levels of psychological health amongst employees (Gebhardt & Crump, 1990; Theorell, 1993; Cooper & Cartwight, 1994; Cooper & Williams, 1997). In 1979, Weick urged researchers to focus on the emotional dimensions of work life. Despite Weick's advice, much of the research into management issues has continued on the assumption that people's behaviour is rational, cognitive and stable. Yet, emotions have also been found to comprise aspects of reason, action and feelings, including decision-making and a disposition to act (James, Milton & Gibb, 2000).

Researchers are showing renewed interest in the impact of emotions in organisational contexts (Ashkanasy, Hartel, Fischer & Ashforth, 1998). Research has indicated that, rather than interfering with rationality, emotions may assist in wise decision-making. Conversely, a lack of emotional expression has been shown to result in irrational behaviour (Damasio, 1994). As such, emotional states are no longer regarded as irrational responses to events in the workplace (Nicholson, 2000). A dispositional proclivity to cope with and manage emotional experiences has been popularised as 'emotional intelligence' (Salovey & Mayer, 1990; Mayer & Salovey, 1993; Goleman, 1996, 1998). This study focuses on one aspect of emotional health – affective wellbeing. Although extensive research has been conducted into workplace affective wellbeing and job satisfaction (e.g. Warr, 1990, 1995; Kelloway & Barling, 1991; Kahn & Cooper, 1993) there is no specific empirical research into the impact of affective wellbeing and intrinsic job satisfaction on managers' performance. A research opportunity exists for using affective wellbeing as the predictor variable of managers' performance, in conjunction with intrinsic job satisfaction.

A strong causal link has been established between people management and business performance by Patterson, West, Lawthorn and Nickell (1998). Compared to other management practices (for example, strategy, quality focus, investment in research and development), human resource practices explained 18% of the variation in productivity and 19% in profitability of companies in the United Kingdom. Two clusters of skills, acquisition and development of employee skills (including the use of appraisals), and job design were shown to be particularly important. Patterson and colleagues have established an empirically compelling argument supporting the relationship between people management practices and commercial performance (Patterson et al., 1998).

Managers (along with workers) are pivotal to an organisation's productivity and effectiveness, since they have ultimate responsibility for maximising the resources available for organisations to create value (Jones, 1995). The resource-based view of the firm recognised the value added by human capital (Wernefelt 1984; Hamel & Prahalad 1994). Regardless of the industry or country concerned, managers represent the human capital that is critical to an organisation's success (Williams & Sanderson, 1991). Any decline in managers' performance inevitably results in revenue foregone, opportunities lost, and increased costs. In turn, this hampers the capacity of organisations and, ultimately, national economies to create wealth. Organisations are under increasing pressure to improve productivity, while simultaneously reducing costs, resulting in an epidemic of 'corporate anorexia' (Hamel, 1996). A new enterprise formula is emerging – '1/2 x 2 x 3' – whereby half as many people are being paid twice as much, to produce three times more (Handy, 1995, p3). This trend to 'squeezing the pips' is particularly evident for managers, where the incidence of stress and burnout is increasingly common (Quinn, Faerman, Thompson & McGrath, 1996; Reinhold, 1997).

Of the three psychological aspects of burnout (emotional exhaustion, depersonalisation, diminished sense of personal accomplishment), emotional exhaustion is increasingly prevalent in western workplaces (Lee & Ashforth, 1996). To reach and sustain heightened levels of performance, and to avoid burnout in this environment, it is desirable that organisations develop strategies for maintaining managers' affective wellbeing and intrinsic job satisfaction. Organisational dynamics experienced by Australian managers are indicative of those facing most nation-states and economies. Handy (1996) considered the '1/2 x 2 x 3' formula 'about right' for Australia, New Zealand, the United Kingdom and North America. Findings from this study may be applicable to managers in other working situations because managers are critical to the success, or failure, of companies and organisations (Carlopio, Andrewartha & Armstrong, 1997).

By establishing how affective wellbeing and intrinsic job satisfaction influences performance, it is possible to predict how a deterioration, or an improvement, in affective wellbeing and intrinsic job satisfaction impacts on managers' performance. Similarly, management practices that increase managers' affective wellbeing and intrinsic job satisfaction may result in corresponding reductions in workplace tension and improved efficiency. Such information may be used to develop recommendations about changes likely to promote a healthier and more supportive work environment for managers.

Study design and data analysis

Questionnaire items were derived from literature to support using affective wellbeing and intrinsic job satisfaction scales. Managers' contextual and task performance scales were developed also through an analysis of literature. Questionnaire items were further refined using feedback from expert reviewers and a pilot survey. A cross-sectional survey was administered to managers (N=1,552) from a range of occupational groupings in 19 Western Australian private, public, and third sector organisations.

An empirical methodology was used to test the hypotheses to enable the research questions to be answered and to suggest *A Partial Model of Managers' Affective Wellbeing, Intrinsic Job Satisfaction and Performance*, as shown in Figure 13.1. Self-report data used established affective wellbeing and intrinsic job satisfaction measures, while supervisor-ratings, developed from the literature, provided an evaluation of managers' contextual and task performance.

Answering the research questions required developing an instrument to measure the structure of managers' contextual and task performance. An eight-dimensional measurement model of managers' performance, derived from the survey data, was tested using exploratory and confirmatory factor analysis to differentiate the structure of managers' contextual and task performance. A measurement model of managers' performance dimensions was confirmed to be multivariate and consist of eight distinct dimensions. The performance construct was operationalised in terms of four contextual dimensions (*Endorsing, Helping, Persisting, and Following*) and four task dimensions (*Monitoring, Technical, Influencing, and Delegating*).

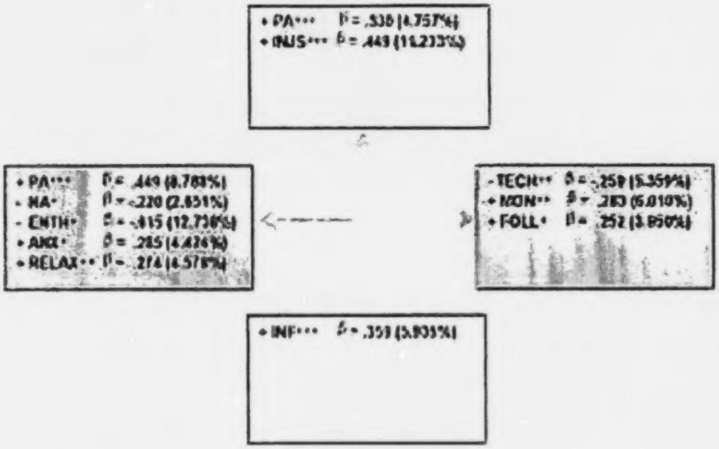
These dimensions were confirmed through multi-sample analysis and cross-validation techniques of managers' and superiors' ratings. A commonality of perceptions about what constitutes managers' performance was established between managers and their superiors. Indicators forming these scales are of most interest to managers and their superiors in these organisations. Superiors' ratings were found to be the more reliable of the two methods and are therefore the most appropriate for use as a dependent variable relating to affective wellbeing and intrinsic job satisfaction.

Performance was assessed in term of superiors' ratings of managers' performance and related to managers' self-report of affective wellbeing and intrinsic job satisfaction in order to establish if there was any relationship between the covariates. Thus, the sources of the data were independent. An association was found between some measures of managers' contextual and task performance, affective wellbeing and intrinsic job satisfaction. This association was explained by two orthogonal variates (that is, each pair of variates is independent of all other variables in the data set) of managers' affective wellbeing, intrinsic job satisfaction and performance as shown in Figure 13.1.

Statistical methods

Canonical correlation and standard multiple regression were used to analyse the linear combination of managers' affective wellbeing and intrinsic job satisfaction with contextual and task performance. Canonical correlation is a 'multivariate statistical model that facilitates the study of interrelationships among sets of multiple dependent variables and multiple independent variables' (Hair, Anderson, Tatham & Black, 1995: 444).[1]

Multiple regression analysis is a statistical technique for analysing the relationships between a single dependent (criterion variable) and several predictor variables (Hair *et al.*, 1995).[2] Affective wellbeing and intrinsic job satisfaction were designated as the independent variables and contextual and task managers' performance as the dependent variables.


• PA*** β = .338 (4.757%)
• INJS*** β = .443 (11.233%)
• PA*** β = .449 (8.703%)
- NA* β = -.220 (2.831%)
- ENTH* β = -.415 (12.738%)
• ANX* β = .285 (4.426%)
• RELAX** β = .274 (4.578%)
- TECH** β = -.259 (5.359%)
• MON** β = .283 (6.010%)
• FOLL* β = .252 (3.850%)
• INF*** β = .353 (5.935%)

Note: * p = <.05; ** p = <.01; *** p = <.001.

Figure 13. 1 A partial model of managers' affective wellbeing, intrinsic job satisfaction and performance

Results

A large amount of the variance of managers' performance was explained by affective wellbeing and intrinsic job satisfaction. The first canonical variate explained 31.25% (multiple R = .559) of the variance of performance and the second canonical variate explained 21.16% (multiple R = .460) of the variance of performance.

Affective wellbeing self-report (Positive Affect, Intrinsic Job Satisfaction) was found to be positively associated with a dimension of superiors' reports on task performance (Influencing). Positive associations for dimensions of affective wellbeing self-report (Positive Affect, Anxiety and Relaxation) were also found to be negatively associated with dimensions of superiors' assessments of managers on task performance (Monitoring) and contextual performance (Following) that was also negatively associated with the task performance dimension (Technical). As predicted, positive affective wellbeing was related to enhanced managerial performance, whereas diminished affective wellbeing indicated poorer performance.

Figure 13.1 shows that for the first canonical variate, PA and Intrinsic

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Job Satisfaction are strongly associated with Influencing. PA is a trait personality characteristic associated with extroversion, a personality characteristic that is central to managerial jobs in dealing with peers, superiors, subordinates and external constituents. Possibly, an engaging personality is the reason individuals are promoted or self-select into managerial positions. PA may enable managers to influence decisions from which they derive considerable Intrinsic Job Satisfaction, which has a substantial cognitive component. Alternatively, the opportunity to Influence decisions within an organisation may result in enhanced Intrinsic Job Satisfaction and heightened PA.

The canonical variate showed a complex set of relationships between aspects of affective wellbeing, intrinsic job satisfaction and performance. PA, Anxiety and Relaxation were positively associated with the contextual performance variable, Following, and the task performance variables Monitoring and Technical, while NA and Enthusiasm were negatively associated with performance variables (Technical, Monitoring and Following). This indicated that high arousal (positive PA with negative NA) was present, but job dimensions were not particularly motivating (as indicated by negative Enthusiasm but positive Relaxation). This finding indicates managers will experience arousal but low distress when undertaking transactional or administrative roles.

Another explanation for the second canonical variate may be that aspects of managers' jobs requiring essentially transactional or administrative roles (negative Technical, with positive Monitoring and Following) may lead to high arousal with positive PA and Anxiety, but provide opportunities for Relaxation in conjunction with negative Enthusiasm and NA. A positive association with Monitoring and Following indicated these performance characteristics require vigilance and consequently high arousal (Anxiety and PA with the attendant NA), but do not lead to a motivating environment (negative Enthusiasm).

However, Monitoring and Following provide opportunities for Relaxation leading to acceptable levels of affective wellbeing. Managers also reported PA, a personality trait, to be the only variable common to both dimensions of contextual and task performance, indicating it is a prerequisite for managerial jobs. From this finding it could be inferred managers will have a positive disposition to work. This has implications for the recruitment, selection and development of managers.

As predicted, positive affective wellbeing and intrinsic job satisfaction was related to enhanced managerial performance and poor affective wellbeing indicated reduced performance. Affective wellbeing self-report

(Positive Affect, Intrinsic Job Satisfaction) was found to be positively associated with a dimension of superiors' report on task performance (Influencing). Positive associations for dimensions of affective wellbeing self-report (Positive Affect, Anxiety and Relaxation) were found to be negatively associated with dimensions of superiors' report on task performance (Monitoring) and contextual performance (Following). These performance variables also negatively associated with the task performance dimension (Technical).

Unless otherwise stated, it is assumed, as reported in the literature, that the direction of the relationship between the variables is from affective wellbeing, intrinsic job satisfaction to performance (Warr in Kahneman, Diener & Schwarz, 1999). However, this should not be taken to infer causality between the dimensions of affective wellbeing, intrinsic job satisfaction and managers' performance. These findings make predictions about the directions of managers' affective wellbeing, intrinsic job satisfaction and performance but causality between these variables was not tested.

Implications for human resource practices

This study was based on the popular notion that affective wellbeing and intrinsic job satisfaction predict performance. The 'happy-productive' worker thesis is yet to receive unequivocal empirical support. It was revisited in this study using robust measures of the constructs of affective wellbeing, intrinsic job satisfaction and managers' performance. Rated performance of managers was previously conceived as a unidimensional construct. In this study, multi cross-validation of self and superiors' ratings found managers' performance to be a multivariate construct consisting of both contextual and task performance. These findings provide an opportunity for researchers to extend the theoretical development of affective wellbeing and intrinsic job satisfaction in relation to managers' performance.

A number of implications for human resource practices emerged from the study. The main recommendation is that organisations should consider initiating ways to improve managers' affective wellbeing, intrinsic job satisfaction and performance. This will assist human resource practitioners to align human resource practices within the broader framework of organisational strategies. As global market forces become more pervasive, optimising so-called hard and soft human resource strategies is likely to become more important to enhancing managerial health, performance, and organisational prosperity. This position is predicated on the assumption that improved affective wellbeing and intrinsic job satisfaction may result in improved managerial performance, which will eventually result in increased organisational productivity. Enhanced individual performance may result in increased benefits and reduced organisational costs, and ultimately more effective organisational outcomes.

The potential of workplace initiatives to improve the quality of managers' working lives and organisational effectiveness is considered. In combination, these benefits may result in more effective organisational outcomes including increased productivity, reduced organisational costs, reduced staff turnover; and avoidance of protracted legal actions arising from claims of unfair dismissal, breach of contract or diminished affective wellbeing. This study investigated an aspect of human behaviour with the potential to enhance managerial performance. A better understanding of how affective wellbeing and intrinsic job satisfaction influences managers' behaviour was posited to improve aspects of managers' performance. The eight-dimensional measurement model of managers' contextual and task performance is suitable for replication. Suggestions were made about how managers' jobs might be changed to enhance, or to avoid a decline in, affective wellbeing, intrinsic job satisfaction and performance in order to improve overall organisational effectiveness.

Endnotes

[1] For studies with multiple dependent and independent variables, canonical correlation is the 'most appropriate and powerful technique' (Hair et al., 1995, p444). Canonical correlation is suitable for assessing the relationship between metric independent variables and multiple dependent measures to ascertain the strength and the nature of the defined relationship (Hair et al., 1995).
Canonical correlation answers two related research questions. First, what is the degree of the relationship between the sets of variables (e.g. predictors and criteria), and second, what is the nature of the relationship between these sets of variables? The latter attempts to establish the number of dimensions and the underlying dimensions that explain these relationships. Optimal dimensionality is identified by a canonical correlation to maximise the relationship between each set of independent (affective wellbeing and intrinsic job satisfaction) and dependent variables (contextual and task performance). Measures of the relative contribution of each variable to the canonical functions are then extracted.

[2] The regression analysis procedure ensures the maximum prediction from the set of independent variables by weighting each independent variable. A standard multiple regression was used on the predictor variables to test the specified hypotheses. Standard multiple regression analysis is used to predict dependent variables from the knowledge of one or more independent variables (Tabachnick & Fidell, 1998).

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14 Community care: creating efficiencies and raising concerns

Sue Stack

This paper summarises some findings from two case studies that explored the delivery of community health care and the interrelationships among the nature of care work, workplace organisation, labour process and worker characteristics. It suggests meaningful work for care workers, their own wellbeing and that of those for whom they care, largely depends on recognising these interrelationships. The paper begins by noting some key points about the nature of care work and the market-based arrangements under which community care is being delivered. It goes on to outline the two different types of community health care organisations studied and the contemporary work organisation and management approaches they adopted. The studies capture both professional and relatively unskilled care workers, and highlight the caring values they share. The paper identifies ways in which a focus on efficiency and cost minimisation can confront professional care workers' values. It also raises concerns about risk for some of the in-home care workers and their clients.

The nature of care work

An earlier paper (Stack & Provis, 2000 and references therein) provides a reminder of key points about 'caring' and 'emotional labour' in the context of health care delivery. In particular, the important role that relationships between clients and carers have for effective caring.

People care for others when they experience some emotion for them: some feeling of compassion or sympathy. People also care for one another when they promote or maintain their welfare. It involves:

> ...attending, physically, mentally and emotionally to the needs of another and giving a commitment to the nurturance, growth and healing of that other (Davies, 1995 p19).

James states that in health care work:

> the emotional labour involved in building a relationship with a client and their family takes time and requires considerable knowledge of the patient as a person (James, 1992, p503).

This aspect of health care is as integral to medical competence as are knowledge and skills, because caring fosters the bonds of trust that enable doctors and their patients to communicate (Scott, Aiken & Mechanic 1995, p78). These elements of trust and communication are important for effective diagnosis, prescription and patient compliance with prescribed regimens, and their importance for those providing 'professional' care seems clear.

At the other end of the qualification spectrum, Aronson & Neysmith (1996) note home care work for old people may involve important affective dimensions, including companionship, emotional support and others. Davies (1995, p19) distinguishes this type of 'caring work' from 'professional care' and 'caregiving'. By 'professional care' she refers to a form of public caring work undertaken by those who have received systematic and formal training, while 'caregiving' is used to refer mainly to the caring that is done on an unpaid basis within networks of family and friends.

Care work, such as in-home care work, can be seen as the commodification of labour formerly performed within the domestic household and it is increasing for a number of reasons. Some of these have to do with the combined effects of ageing of the population and government policies of deinstitutionalisation of care for both the aged and disabled. Other reasons include health fund policies resulting in shorter hospital stays. Cumulatively, these create a demand for caregivers, while social and demographic changes that are reducing the pool of potential unpaid caregivers to provide care have been noted for some time (Walker, 1983).

There are a number of 'service' occupations such as teaching, nursing, policing, and others, where the emotional strain of working closely with people is a constant part of the daily job routine. The 'people work' involved in delivering health care is generally recognised as a particularly demanding form of emotional labour (Foner, 1994, p4), and the emotional strain involved in this work can be distinguished from the sort of service work performed in commercial operations such as those studied by Hochschild (1983). Her work explored the emotional pressure experienced by flight attendants and debt collectors, and in those cases the pressure arose from workers having to display emotions they did not authentically feel. Subsequent empirical results are mixed about the extent to which 'inauthenticity' poses problems such as psychological stress and burnout (see Provis, 2001, p2) and, more generally, it has been noted that the stress care workers experience can be influenced by their personal characteristics. Some of these are also likely to be implicated in an individual's original choice of a helping profession as a career (Maslach, 1982, p57).

The focus here is on authenticity from a different perspective. The emotional discomfort experienced by health care workers in the study organisations occurred largely because they authentically cared for individuals, however they were prevented from effectively doing so. This could result from the rules under which they served or because of limitations on the resources or training available to them to provide that care. Relating the requirements for effective caring to some emotional burdens for care workers, the significant impact of organisational structures is noted. It is structures built on hospital models of efficient, almost mechanised care that rob hospital and nursing home care workers of the ability to form close, beneficial attachments with those for whom they care (James, 1992, p496; Lescoe-Long, 2000, p72).

Many of the issues that arise about the emotional labour involved in a nurse's caring for a patient include ones about the effect of bureaucratic structures. There are tensions between the effective performance of emotional labour and conforming to the rules of a bureaucratic setting. This is particularly so in regard to the establishment of an emotional relationship that involves a degree of commitment to the other person where that may conflict with formal rules. These and other tensions identified by Stack and Provis (2000) can compound the emotional labour content of the work performed by caring labour. Where workers have an opportunity to express their caring values, these tensions might not arise. For some care workers, an ability to express caring values adds meaning to the work they do and the precise nature of how the work is organised and managed influences this. Two different types of organisational settings are explored here. One of these has traditionally allowed opportunities for meaningful caring relationships to develop, but increasingly the work is being organised in ways that inhibit these. In the second organisational setting, these same opportunities are plentiful but some other aspects of effective caring are missing.

The new public management

To a significant extent, the contemporary arrangements for organising and managing the care work in the study organisations reflect aspects of workplace change brought about by new approaches to public sector management. As well as new public and private health policies and funding, there are newly created and amalgamated health care providers affording increased competition. Many of the developments in these areas reflect the beliefs and values embodied in new public management (NPM) and, relatedly, managerialism (for some relevant material on NPM, see Pollitt, 1993).

A philosophy or ideology of 'small government is good government' has underpinned change in public sector management (see Lerner 1982). It is based on a belief that traditional bureaucratic government is not a means to social betterment, but a mechanism that distorts private economic behaviour, reduces individual freedom and makes the economy less efficient. These views have led to strategies designed to diminish the role of government, with attempts to shrink the size of the public sector (downsizing, privatisation, contracting out) and other efforts to make it more efficient and competitive.

Competition is one of the key ideas behind market-driven management and is associated with a belief in the efficiency of markets. Competition is intended to lower costs and increase efficiency, and public sector managers are intended to increase their performance levels if exposed to market forces. Another idea behind market-driven management is more generic: an unquestioning belief that private sector practices and technologies are superior to those used in the public sector.

There have been numerous changes to the principles and practice of Australian government under the new 'managerialist' umbrella. These have included: program budgeting; letting the managers manage; managing for results; emphasising outputs rather than inputs; centralising control over finance (but decentralising the authority to deploy those resources); reducing hierarchy; rationalising the number of departments and introducing commercial and corporate principles, such as arrangements to allow competition; contracting out 'non-core' services; and contractualising employment in some areas of government (Orchard, 1998; Curtin 2000; van Gramberg & Teicher 2000). Some of these changes are evident in health and community services in Australia (Considine & Painter, 1997; Painter 1998; Leeder, 1999).

The study reported on here (Stack, 2001) specifically identified cost-cutting techniques, the contracting out of services, the introduction of fees for service, the establishment of business units and entrepreneurial management practices for efficient service delivery. What follows is an overview of two organisations that were part of that study, highlighting the nature of the services each provides and some of the work processes involved. It becomes evident that managerialist attempts to save costs tend to impact on broader aspects of quality care and these can confront workers' caring values. Nevertheless, such impacts are not unique to the study organisations and in many ways they simply reflect the external pressures facing health care providers generally.

The study organisations

The primary focus of the study was on 'flexibility' of one type or another, and in each organisation the study began with a survey questionnaire distributed to part-time and casual employees. That was followed by detailed semi-structured interviews with managers and staff. In *Organisation A*, the in-home care work was largely 'professional care', performed mainly by trained, qualified nurses. In *Organisation B*, it was in-home 'care work' embracing various domestic tasks, but also frequently involving intimate personal services ranging from assistance with daily living activities, such as showering and washing, to more complex procedures such as changing colostomy bags or catheterisation.

Established organisations face impelling reasons to find optimum means of delivering efficient health services. As well as new public and private health policies and funding, there are newly created and amalgamated health care providers affording increased competition. *Organisation B* is one such case. Managers in that organisation report that health and community care programs designed to facilitate home care are thinly spread and have low levels of funding, forcing agencies to provide services as cheaply as possible. Under current arrangements, staff training and organisational support are not well provided for in *Organisation B*. This is not the case in *Organisation A*, where training and professional development are a priority. However, there are other features of work organisation impacting on effective caring in that organisation. This paper does not attempt to give a full or detailed account of the data, but to identify some aspects of community health care delivery that raise concerns about the drive for market-based efficiencies.

Organisation A

This organisation is a large, established home nursing organisation that provides 24-hour home and community nursing and allied health care. The way the work is organised resembles that in other similar organisations. Traditionally, 'teams' of registered nurses have performed the community health work. The teams, operating from geographic bases known as business units, are allocated 'rounds', a caseload of patients within their defined geographic area. Prior to beginning their rounds, nurses attend their business unit's office for a short time to collect information regarding their caseload. From there, they take a motor vehicle for the day, the remainder of which they spend 'on the road' visiting and attending clients. They return at day's end to write up patient notes, return the vehicle and catch up on internal communications. The staff in *Organisation A* are predominantly women aged thirty and over.

In the past, the work undertaken by these nurses has been broad-ranging, from tasks associated with daily living activities such as showering and bathing patients, to wound care, administering medication (recently via intravenous infusion), rehabilitation and physiotherapy. In addition to these clinical aspects, community nurses have traditionally viewed their work as involving health promotion and preventative care. They have been generally attuned to patients' social and psychological needs as well as their immediate physical surrounds, often attending to aspects of patient care and wellbeing related to those factors. Examples include attention to dietary needs of patients, checking the fridge to ensure it contains staples and discarding old, mouldy food. They may also have made telephone calls to sort out issues for patients, collect medication from the pharmacy or drop something in the post for them. Across a range of issues, they have been able to determine priorities to complement any medical opinion or direction they have received about the patient in question and while on the road they have worked autonomously.

Changes that have been occurring in the organisation are partly a consequence of the more general health sector changes alluded to above: social changes and policies of deinstitutionalisation have increased the numbers of people needing care in their own homes. A result is that community nurses now find themselves responding to broader needs, and sometimes more acute ones, with increased demand for their services overall. During the course of the study the organisation was accepting 1,000 new clients a month, with 45% of those coming directly from hospitals.

The ways in which some of the changes to work process and management prerogative in *Organisation A* impact on professional care workers are noted below. Here it is noted that delivering health care in people's own homes involves care workers, professional and relatively unskilled, exercising independent judgment, in the absence of direct supervision. The professionals in *Organisation A* have traditionally enjoyed high levels of autonomy, reflecting both primacy of expertise and the complexity of service delivery. The impact of managerialism in this organisation is similar to that noted elsewhere, where the growth in power of accountancy over health professionals challenges their autonomy (Malin *et al.*, 1995, p.45). There is evidence in *Organisation A* of task fragmentation, work intensification and centralisation of work planning.

Organisation B

In the context of NPM, the provision of health care services via a for-profit organisation represents a case of contracting out services to the private sector. *Organisation B* has been operating for six years as a private home care agency arranging a variety of increasingly complex services, either short or long-term, for an expanding and diverse range of people requiring assistance to manage their health and personal care needs in their own homes. A distinctive feature of the organisation is that it delivers its services through a fluctuating but large number of casual employees, the majority of whom are female. There is also a high turnover of staff in this organisation. Some of the care workers are trainee nurses, others are registered nurses who have let their registration lapse. Some have community care certificates, while others come to in-home care with no formal training or experience outside caring work performed within their own families.

In terms of work process, individualised responses and flexibility are the norm. While the work allocated to carers takes place within a defined block of time, within that time frame the tasks are altered and negotiated to fit around the individual, paralleling domestic or family care work. For example, the client may ask to stay in bed for an extra half an hour, suddenly leaving the carer to do other things then, rather than later. The sustained and close relationships some workers describe means they are attuned to clients' needs and adjust the timing and performance of physical tasks to accommodate these. It is not uncommon for a carer, while performing some other task, to perceive a need to give some direct attention to a client, based on the carer's 'feeling' or 'intuition'. In such cases the current task is interrupted, and continued at some future time.

In contrast with the physical labour of care work in hospitals or other institutions, the form of domestic care provided in the home by the casual employees of *Organisation B* relates directly to the client. It is less well-defined or accountable and significantly more flexible. This is not to say some of the physical tasks are not routine or predictable (as in hospital domestic work), but constantly responding to the state of the client permeates the work of the carer. This occurs even while both parties sleep. Care workers refer to the use of baby monitors so that they can detect changes in clients' breathing while they themselves attempt to sleep in an adjoining room.

In the work done by employees of *Organisation B*, determining what is appropriate is largely left to the individual worker. No management controls tell the carer when to leave off one task, move to another or check on the client. In cases where the client is in severe difficulties, it is up to the carer to decide when it is appropriate to call for professional back-up. Again, in some households where several carers deal with the same client, but at different times, a communication book provides a system of communication and feedback among the different carers. Whether or not something goes into that book, and what goes in, is left to the discretion of the carer. Nobody formally collects the books or monitors the entries for purposes of performance management. The effects of NPM are primarily through the competitive environment that has been created for this and other similar organisations.

One feature to emerge from the study is that both professional and relatively unskilled care workers share some common caring values and these are reflected in the concerns they express for the wellbeing of their clients. Another is that the affective dimensions of care work professional workers in *Organisation A* have traditionally accepted responsibility for, and add meaning to their work, are being squeezed out in the interests of efficiency. This is partly a result of work intensification but also a result of other management practices. While this is not the case in the development of affective relationships between care workers and their clients in *Organisation B*, where the care workers raise different issues, about quality and a lack of appropriate training for the work they are required to perform. Let us turn now to hear what employees say about changes occurring in their organisations and the concerns they have about these for the delivery of health care.

Concerns

Desirable aspects of caring work appear to be crowded out for reasons of efficiency in a range of areas. In the case of *Organisation A*, these include not allowing community nurses to spend more time with in-home patients than is necessary for purely medical purposes, but which would otherwise enhance effective caring. They also include other work processes and work organisation that diminish scope for collegial interaction and effective team communication, which is known to affect the sustainability of effective caring. In *Organisation B*, it is plausible to suggest employment practices contributing to high employee turnover and undervaluing investment in training and development of employees, are the result of a 'business' orientation, but partly also a result simply of low funding levels for the sort of care provided. However, high levels of employee turnover and lack of employee training and development detract significantly from quality care in settings where work is performed in people's homes by relatively unskilled workers, and in the absence of direct supervision.

In *Organisation A*, the nature of the services offered is changing as a result of the health funding mix. Hygiene assistance is now only offered to those who pay for it (either privately, or as clients of a government agency). It is also offered to early-discharge from hospital clients for 28 days, because health insurance funds this period. During that time, other alternatives – neighbours, friends or other agencies – have to be organised. For *Organisation A*, early discharge from hospital accounts for 50% of their clients and represents a growth area for the organisation, increasing admissions over one year by 23%. The organisation has responded to these changes by altering work practices, specifically admissions procedures, to ensure it only accepts those patients whose needs are directly funded. Patients with needs ancillary to what the organisation is funded for can no longer be included as part of admissions procedures. The human resources director described the *'terrible, traumatic'* effect this has had on nurses who were distressed at having to tell clients they could no longer attend to their care needs:

> *If someone comes out of hospital, we can only go in for showering twice a week for four weeks. But we've got a lot of people with fractures and a fracture doesn't heal in four weeks and it's very difficult to say 'today's your last day.'*

While workers may be relieved of their concerns if they know the clients' needs will be met by other agencies, nurses in *Organisation A* were not confident this would happen.

New management systems that compress clinical functions into time spans consistent with maximising productivity have made it more difficult for workers to establish relationships with clients. After attending to prescribed clinical tasks, the worker has little time left to engage in diffuse social interaction of the sort needed to deepen and extend such relationships. In other words, they no longer have time to more generally explore, discuss and respond to the range of psychosocial issues that may be influencing the general wellbeing, and relatedly, the specific clinical health of clients. Attention to this broader range of clients' needs is consistent with aspects of effective caring noted above, and the CEO of *Organisation A* acknowledged the likely impact on quality when he was quoted as saying:

> *...we've got some nurses seeing about 16 or 17 clients a day...I can't keep asking them to see more; the quality of care goes down.*

Organising work around pre-booked appointments, and servicing as many of these in a day as possible, also effectively amounts to work intensification and creates a further mechanism for performance measurement.

Other initiatives, such as reallocating staff to different rounds every six weeks to prevent them from over-identifying with clients, has implications for continuity of care that is known to be important to effective caring (Scott *et al.*, 1995). Work intensification also makes general intra-group discussion more difficult, particularly when accompanied by a form of work organisation that has nurses 'on the road' all day. It appears to inhibit opportunities for staff to meet one another for general discussion of client wellbeing and related matters, opportunities that might otherwise be available if there was a time and a place for them to gather. A staff member noted that one way around this was for nurses in some teams to use their own time:

> *We have a designated meeting place [where] we all meet around midday ... not only do you have lunch but we help each other out with what's happening ... but there are other teams where if you're out all day you would have lunch in the car.*

The introduction of new technology to improve efficiency also diminishes opportunities for collegial interaction by limiting the extent to which nurses are required to return to the office. Instead, they are expected to do much of the liaison work with doctors and other health providers via mobile phones, in their vehicles. Management describes these initiatives as *working smarter*.

In addition to the fee-for-service initiative, another feature of NPM includes the introduction of more enrolled nurses to minimise labour costs. While effective as a cost-saving mechanism, the added work involved for managers and team leaders to ensure the right skill-mix in each team means an increase in the transaction cost of managing and organising the teams.

The above arrangements, coupled with part-time or casual forms of employment, heighten workers' concerns about lack of continuity with clients. Almost half the study participants in *Organisation A* referred to 'missing out on communications at the workplace and continuity with the client' as the most unattractive feature of their part-time or casual form of employment.

Related to these forms of employment, a common theme to emerge in discussions with managers and staff was the established practice of providing employees with opportunities to move between full-time and part-time work, and with shift patterns that accommodate their personal needs. Those who worked part-time did so primarily to balance their paid care work with the caregiving they provided to their families. This arrange-ment enhanced their own wellbeing (and it is reasonable to suggest, that of their families also), and they expressed high levels of satisfaction with forms of employment that met those needs. However, aspects of managerialism (see O'Donnell, Allen & Peetz, 1999) emerged during interviews with managers. Those who had previously 'bent over backwards' to accommodate employees' desires to balance their work and family commitments, were changing their approach. Despite staff having clear needs for flexibility in their employment arrangements, increasing use was made of managerial prerogative in managing part-time staff. Managers were rationalising their shift in attitude in the following terms:

> *I'm of the view that the world has changed and we can no longer afford to have someone employed to spend a great deal of their time negotiating with people.*

There was a clear tension between recognised labour characteristics, accepted custom and practice, and the perceived need to grapple with change. Organisations seek increased commitment from employees, but effective caring labour requires employees who concentrate more on the needs of individuals than of organisations and while some of those individuals may be the organisations' clients, others may include the workers' families or the workers themselves. Interviewees were frustrated by the impact of work intensification and changes to work organisation, and its effect both on the clients and themselves.

This is suggestive of two things: there may not be sufficient participation by those employees of their concerns; and where this has occurred, it has been overwhelmed by other aspects of managerialism. Professional carers, such as nurses, have long been recognised as good at getting 'the whole story' and of engaging in everyday caring practices that sustain effective support and communication. Proponents of a nursing ethic of care suggest that such an approach encourages nurses to focus on people, not on rules (Kuhse, 1997, p10). An implication is that organisational rules arising from NPM techniques of measurement and quantification may confront and contradict the requirements of nurses' ethic of care. This seemed to emerge clearly in interviews. Implicit in nurses' concerns about not having enough time with their clients, of feeling rushed and of lack of continuity, was their focus not only on their own wellbeing, but also on particular clients and their needs. These concerns identified some unexpected and unwanted outcomes of entrepreneurial techniques in the public sphere.

In *Organisation A*, senior management personnel were adamant in their expectations that employees should demonstrate commitment to the organisation's new private sector values. Recruitment, access to training and development, as well as subsequent promotion, all hinged on attitudes and behaviours illustrative of a 'private sector mentality'. Those with part-time or casual forms of employment were disadvantaged in this respect as it was not always possible for them to do things such as attend meetings or training sessions in their own time, behaviours that would demonstrate their commitment. This was the case because part-time and casual staff had caring commitments to others outside the organisation. Managers acknowledged the process of selecting staff for management training relied on some informal assessments of whether staff exhibited the 'right attitude'*:* one consistent with a putative private sector approach.

There may be two or three reasons why Organisation B does not have to seek 'the right attitude' from employees. One is that all care workers employed by the organisation are casual employees. Associated with this is the fact that unlike the qualified employees of *Organisation A*, employees of *Organisation B* have not usually undergone years of training to produce a set of values and commitments that may conflict with organisational demands. Another reason is that *Organisation B* is relatively new compared with *Organisation A*, where not only employees' training but the organisation's own traditional culture may not square with NPM principles. *Organisation B* exists largely as a result of government rolling back institutional services to the aged and disabled. This process of deinstitutionalisation is said to reflect, in part, the wishes of people to live in their own homes, and to that extent reflects a market-driven response to individual preferences. The provision of in-home care by private service providers such as *Organisation B* helps achieve this.

However, training remains a major issue in connection with *Organisation B*. It emerged from the study that care workers in this organisation often found themselves in situations for which their induction and training had not prepared them, and for which their skills were inadequate. Whereas 94% of respondents in *Organsiation A* had received induction training, only 37% of respondents in *Organisation B* had done so, and most *Organisation B* interviewees spoke despairingly about what they were witnessing as a result of inadequate training and preparation of care workers.

The litany of experiences included: not being told their client's rehabilitation program involved an exercise regime; finding clients who had not had overnight colostomy bags attended to; staff physically handling clients in an unsafe or undignified manner; staff crushing tablets that are slow release because, ***Well, it goes down her throat easier***; and staff denying clients drinks in case clients become incontinent (***I'll have to change*** *them, you know*). The word 'scary' was used by one interviewee:

> *Most carers wouldn't know one drug from another. I mean if you are given the dosette [sc. a small container with compartments for each day of the week to hold daily doses of medication] I'm supposed to be able to say 'Here you go: here is your medication'. Now half of the clients can't move so you actually have to administer it to them physically yourself. But the thing is you don't know what is in that dosette and many times if you have a flimsy one - and I have done this myself - you take it out and the cover moves and the tablets fly everywhere and you think 'OK' and you have to sort them out and just put them back in without knowing what is being put in or where. So if the next carer comes along there might be half the drugs missing or doubled up and of course with some drugs you just don't double up. So it is scary on the home care side of it, quite frankly.*

Another implied the idea, without using the word:

> *When I had to empty the catheter on the gentleman in the wheelchair I wasn't told anything about it or given any supplies. I was just told to go into this person's place and whatever and I thought 'I would want to wear gloves normally, if I was handling a catheter or whatever'. So I thought I wasn't really told much about that or given enough information about that sort of thing.*

During interviews with managers in *Organisation A*, they referred to market values such as the perceived disproportionate cost of training part-timers versus full-timers, and it seems that similar pressures inhibit *Organisation B* from providing effective training or development for its own casual workforce. Management interviewees noted the compromises being made in respect of training and qualification:

> *We require senior first aid, manual handling and prefer them having gone through one of the recognised courses, but unfortunately demand is usually so high we can't really specify. We just can't get enough trained people so the choice is not so great.*

Some interviewees in *Organisation B* did not have a basic first aid certificate when starting work and had been in the job for three months before getting one. As one interviewee explained:

> *They [sic. the Organisation] allow you to get your first aid certificate in your own time.*

Other interviewees felt a first aid certificate was an insufficient requirement:

> *I've seen carers come from the various agencies that leave a lot to be desired. They say they are a carer but I think there is more to it than a first aid certificate, but it worries me that is all some people have.*

An interviewee describing her frustration with the recruitment, selection and training process summed up her experience:

> *At the interview everyone sat dumbfounded when told [Organisation B] had this quadriplegic that needed help on Sunday morning. This was midweek and they asked who was available for Sunday. I said I was, and expected someone to give me a run down [sc. on what would be required]. Instead they gave me a name and address and the time to be there. That was my training for a quadriplegic. I had never touched a quad in my life.*

In *Organisation B*, the way the work is organised allows care workers to develop close and sustained relationships with their clients, allowing for effective caring. Nevertheless, there appear to be some health and safety issues for workers and their clients, resulting from inadequate training and preparation of that organisation's care workers.

Conclusion

These two case studies highlight some outcomes when the professional, public provision of in-home care transfers to the private sector. Although well-qualified, and with an intimate knowledge of clients and their care needs, professionals in *Organisation A* are increasingly subject to management controls over the precise nature of the care and how that is to be delivered. The important affective dimensions of caring, such as attending to the psychosocial aspects of client wellbeing that have traditionally added meaning and context to their work, now elude them. Opportunities to develop those same dimensions of care and opportunities to exercise independent judgment are evident in *Organisation B*, but in that case, workers have minimum qualifications and training on which to base their decisions. Thus, they risk inappropriate caregiving responses. Care workers are frustrated by this and burdened by the knowledge that it poses risks for themselves and those in receipt of their care.

The case studies illustrate some outcomes of a focus on efficiency and cost minimisation consistent with managerialist approaches to service delivery. These outcomes raise concerns about contemporary arrangements for community care where those arrangements do not fully take account of the interrelationships among the nature of the work, workplace organisation, labour process and worker characteristics.

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WORK LOAD
JOB INSECURITY
TIC
TIC
GK

15 Regulation of emotions in the helping professions: nature, antecedents and consequences[1]

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Do hospital employees regulate their emotions so they are in line with their job requirements? What effects do such regulation processes have on workers' psychophysical wellbeing? What variables mediate their frequency, nature, and effects? To answer these questions, Italian men and women (N=180) working at a hospital as nurses, doctors, or in other technical roles, were administered a questionnaire comprising several scales, plus questions on socio-demographic and work-related variables. Results showed the regulation of felt emotions, that is, *Emotional Labour* (Hochschild, 1983) is a relevant variable of such jobs. Workers performed both (a) *Surface Acting*, that is, controlling *expressed* emotions so they are contextually adequate, and (b) *Deep Acting*, that is, trying to actually *feel* the required emotion; plus (c) *Emotional Consonance*, that is, effortlessly feeling the job-required emotions, was also a frequent experience for employees. Further, results showed the nature and frequency of such regulation processes have significant relations with both objective job-related features, such as the time spent in listening to patients, and with psychological variables such as burnout, and pleasurable emotions.

Introduction

Increasingly, understanding people's wellbeing in the workplace has become an important concern to many psychological and social scientists. A large part of most people's life is spent working in jobs that almost necessarily imply emotional content. A person's job is the source of a variety of emotion-related processes and outcomes, including the intensity and frequency with which pleasant emotions (for example joy, calm and pride) or negative ones (for example anger, shame, sadness) are experienced. It may be hypothesised that such emotion-related processes might constitute important parameters in defining not only working-life quality, but also a person's wellbeing. As a consequence, the emotions, and their underlying processes, experienced by people in relation to their working lives, are an area of major research interest (Ashkanasy, Hartel & Zerbe, 2000; Fisher & Ashkanasy, 2000). Moreover, service organisations that involve employee-customer interactions, such as hospitals, public or private offices and schools or banks, are starting to pay greater attention to the quality of their services, including the quality of customer/service provider relations. The emotional style with which employees in service jobs offer a service is in fact an integral part of the service itself (Hochschild, 1983), so much so that service and business organisations often try to govern and control such style by rules dictating what emotions must be expressed (Rafaeli & Sutton, 1987). Customers' evaluation of interpersonal aspects of their interaction with the provider contributes to defining their judgement of service quality; this evaluation, in turn, tends to reflect employees' feelings about their job and their organisation (Rafaeli & Sutton, 1987; Pugh 1998). Hospital workers are asked to comply with the organisation's emotion-style requirements.

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Emotional labour, a concept - originally developed by Hochshild (1983) - denoting processes of emotion regulation as it occurs within work contexts, may be defined as the employee's management of emotions in order to display emotions congruent with job requirements in his/her vocal and/or face-to-face interaction with customers. Central in this approach to emotion regulation is the hypothesis that regulation implies a certain amount of psycho-physical effort, and therefore a psycho-physical cost (Hochschild, 1983; Morris & Feldman, 1996, 1997; Grandey, 1998). This chapter focuses on health care professions. As regards *health care workers*, researchers have documented they are often burdened with physical and emotional exhaustion, depersonalisation, and a low sense of personal work realisation (Maslach & Jackson, 1981, 1984; Maslach, 1993; Lee & Ashforth, 1996). Several burnout causes have been documented, including time pressure, too much work, lack of support, inadequate skills, poor work environments, emotional demands made by customers (for example, hospital patients), poor relationships with peers and higher-in-rank-colleagues, and role conflicts and ambiguities. The study reported here aimed to provide a better understanding of the extent to which processes of emotion regulation are a crucial aspect of health care workers' jobs, and analyses what kind of regulation processes need to be activated, how frequently, their antecedents and consequences, and whether emotional labour might be a causal component of burnout.

Emotional labour in the 'working life' of hospital structures

In service jobs, workers might experience situations in which they need to regulate their emotions in order to comply with job requirements. Emotion regulation, that is, of the felt emotion, or its expression, is called for when the felt emotion conflicts with known internalised norms, or with contextually salient ones, or, more generally, when a person experiences dysphoric emotions. This study focuses on *emotional labour* (Hochschild, 1983), that is, emotion regulation as it occurs within work contexts. As mentioned earlier, in many different kinds of service jobs, employees have to regulate their feelings and their emotional expressions to be congruent with their organisation's 'feeling rules' and 'display rules'. That is, with those emotional norms defined by organisations in order to induce positive states in customers, thus maximising the probability of positive judgements of service quality. To the extent felt emotions conflict with job-congruent ones, we might hypothesise workers will experience emotional dissonance or discrepancy; that is, an unpleasant psychological state that occurs when feelings differ from expression (Morris & Feldman, 1996; Grandey, 1998). Because workers are often explicitly instructed and/or trained about their job emotion requirements, and the organisation controls the quality of employees' emotional service performance, workers might try on such occasions to express job congruent emotions; that is, perform emotional labour or implement some kind of emotion regulation. This is a process implying emotional effort (Morris & Feldman, 1996; Grandey, 1998, 2000; Kruml & Geddes, 1998).

Emotional labour implies a dual task; that is, both not showing job-incongruent felt emotions (for eample, one's own happiness during an interaction with a sick hospitalised patient), and actually expressing job-congruent emotions (for example, expressing concern for the patient's health). Emotional labour may be performed in two ways. In *Surface Acting*, a shallow form of emotion regulation, a worker simply acts as though he/she feels the context-required emotion (for example, smiling to an annoying patient). In *Deep Acting*, the opposite dimension of emotional labour, an intrapsychic form of emotion regulation, the worker 'pumps up' his/her emotions to actually feel the required ones. If, on the other hand, workers spontaneously feel the required emotions, no emotional dissonance is involved, and therefore they do not need to regulate their felt emotions. The extent to which workers feel job-congruent emotions - also called 'genuine emotions' in the past - might be hypothesised to denote the extent of job-related *Emotional Consonance*.

The extent, nature, and frequency of emotional dissonance, and emotional labour (see, for example, Morris & Feldman, 1996; Grandey 1998; Zammuner, 2002) might be expected to influence workers' psychological wellbeing, for instance by causing emotional exhaustion, or burnout. The way workers interact with customers is to a large extent related to the fit between the worker and their social/organisational context. Health care workers (for example, doctors, nurses, and to some extent technicians) who work in hospitals have many daily interactions with customers/patients, and with their relatives. Such interactions imply a constant emotional involvement focused on the patient's contingent problems – for example, physical, psychological or social. The quality of the human relationship established between the health care employee and the patient is a fundamental aspect of the working activity of health care workers. Therefore, emotion-related requirements are a crucial aspect of the job role of health care professions that include employee-customer interactions. The effort involved in emotional labour might be hypothesised to be in the long run quite detrimental to these workers' wellbeing.

The nature and frequency of performed emotional labour might be hypothesised to vary as a function of relevant job-related variables. In fact, not all service jobs, and not all jobs in themselves, require emotional labour to the same extent and frequency. The specific nature of a job role, within a specific service-sector, is likely to be a crucial variable in predicting various aspects of the required emotional labour. Job-related variables we might expect to be relevant are frequency and duration of an employee's interaction with patients, the employee's level of job involvement, and his/her job experience, in terms of total number of years he/she has spent in his/her present job. Emotional labour might finally be expected to vary as a function of personal variables, such as gender, age, and personal status.

The hypotheses were tested in a study with Italian health care employees whose job demanded interactions with patients. A more general purpose of this study – itself part of a larger research project (Zammuner, 2002) – was to explore in greater depth the concept of emotional labour itself, by focusing on the ways in which, for what reasons, in what contexts, and as a function of what variables, individuals regulate their emotions.

Method

Subjects and procedure

Data were collected by means of a self-report questionnaire administered to 180 medical workers in a private hospital in Italy. Thirty-one per cent were male; 69% female with 24% doctors; 53% nurses; 8% auxiliaries; 7% technicians and 8% administrative employees.

Experimental measures

The self-report questionnaire was initially conceived on the basis of a theoretical analysis of relevant literatures (for example, emotion theories and psychology of work, including recent studies on the emotional labour construct, and on burnout). The questionnaire administered to subjects contained several personal and job-information questions, related to such variables as age, gender, civil status, number of working years, whether subjects had received specific patient-interaction training, and the frequency and duration of interactions subjects had with patients.

The questionnaire comprised five experimental rating scales, plus a control scale on social desirability biases. All scales in the questionnaire were taken from - and usually adapted to the study purposes, especially as regards wording - previous studies carried out with English-speaking subjects. In a few cases, scales had already been translated and used with Italian speaking subjects, as detailed below. More specifically, in addition to an emotional labour scale – a construct measured using a scale version by Grandey (1998, 2000) and constituting a modified scale by Brotheridge and Lee (1998) – the questionnaire included scales measuring varibles related to emotional labour, burn-out (*Maslach Burnout Inventory*), job involvement (*Job Involvement Questionnaire*), affect (*Felt Affect Questionnaire*) and life satsifaction (*Life Satisfaction Scale*). Finally, a *Social Desirability Bias Scale* (a short version of Crowne & Marlowe's [1960] Social Desirability Bias Scale, by Manganelli, Rattazzi *et al.*, 1999) was used to control for biased self-reported answers.

Emotional labour

Emotional labour was measured by a 10-item scale, using a 1–5, Never-Often rating scale. Subjects' responses were factorially analysed, using the Varimax method (see Table 15.1 for item factorial loadings, percentages of explained variance and mean factor scores). The results showed the existence of three independent factors (as originally hypothesised: Hochschild, 1983; Grandey, 1998, 2000). The first two, namely *Surface Acting* and *Deep Acting*, constitute dimensions of emotional labour, whereas the third, *Emotional Consonance* (called genuine emotions by Grandey, 1998) indicates the extent to which emotion regulation is necessary. *Surface Acting*, which gave the highest variance, was measured by 4 items ('Put on a 'mask' in order to express the right emotions for the job'), that express different forms of 'shallow' regulation, that is, simply complying with job-congruent display rules of emotion. *Deep Acting* was measured by only one item ('Try to actually experience the emotions that I must show'). This dimension, in other words, measures intra-psychic regulation attempts. Finally, the *Emotional Consonance* factor ('React to customers emotions naturally and easily') was measured by two items.

Burnout

Burnout was measured by a 22-item Italian version of the *Maslach Burnout Inventory* (MBI; Maslach & Jackson, 1981) using a 1-5, Never-Often rating scale. The factorial analysis confirmed the original three-factor structure, although not all individual items confirmed the hypothesised subscales. More specifically, Emotional Exhaustion was assessed by seven items, Depersonalisation by four items, and Work Realisation by six items (see Table 15.1).

Job Involvement

Job Involvement was measured by a 10-item scale (for example, 'Most of my interests focus on my job') using a 1–6, Disagree-Agree scale. The scale was developed by Kanungo (1982) to measure the extent to which the person psychologically identifies her/himself with the job, rather than with work in general. In this study the scale was partially modified to reduce acquiescence biases. Half the items were re-phrased in negative terms, that is, as statements expressing job non-involvement. A factorial analysis of the scale confirmed the original one-factor solution, explaining a good portion of the variance (see Table 15.1).

Affect

Affect was measured by an 11-item scale, inspired by the Panas test (Watson *et al.*, 1988). For each emotion (for example, joy), subjects reported its frequency in the last two weeks, on a 1–5, Never-Always scale. The factorial analysis showed the existence of three (rather than the original two) factors, which explained a quite high portion of the total variance (see Table 15.1). Positive Affect, the primary dimension as regards the amount of variance it explained, was measured by four items: joy; excitement; love/affection; and pride/sense of satisfaction). Deactivated Affect, the second dimension, was also measured by four items: anger; agitation; calm; and quietness (the latter two items had a negative loading on the factor, and subjects' scores on them were thus reversed). Finally, Negative Affect was measured by three items: shame/guilt; fear; and sadness, and it explained the least amount of variance (see Table 15.1).

Life Satisfaction

Life Satisfaction was measured by the 5-item *Satisfaction with Life* scale developed by Diener, Emmons, Larsen & Griffin (1985) and refined by others (Diener, 1984; Suh, Diener, Oishi & Triandis, 1998). Subjects rated each item (for example, 'My life conditions are excellent') on a 1–6, Disagree-Agree scale. The items express global rather than specific subjective evaluations, allowing for a global judgment of life quality that focuses on the cognitive component of subjective wellbeing. The factorial analysis of operators' ratings on the scale confirmed the original one-factor solution, explaining a very high portion of the variance (see Table 15.1).

Results

Emotional labour dimensions and psychological correlates

Regarding the two dimensions of emotional effort, results showed *Surface Acting*, the 'shallow' emotion-expression regulation process, was positively associated with both Emotional Exhaustion and Depersonalisation (both components of burnout), and negatively with Deactivated Affect, whereas *Deep Acting*, the assumedly more difficult-to-activate regulation process, and a kind that presumably requires greater motivation in order to be successfully performed, displayed a positive correlation with Depersonalisation, and a negative one with Social Desirability.

Emotional Consonance, that is, the extent to which health care workers effortlessly comply with emotional job-congruent norms, showed no association with *Surface Acting*, nor with *Deep Acting*, but showed a significant positive correlation with Work Realisation (see Table 15.1). Regarding the *Burnout* dimensions, results showed Emotional Exhaustion correlated positively with Depersonalisation and Negative Affect, and negatively with Job Involvement, Positive Affect, Deactivated Affect, and Life Satisfaction. In turn, Depersonalisation showed a negative association with Positive Affect, Deactivated Affect, and Social Desirability, whereas Work Realisation was positively correlated with Deactivated Affect and Job Involvement, and the latter was positively associated with Positive Affect, itself positively associated with Deactivated Affect and Life Satisfaction. Negative Affect displayed the same correlations but in a negative direction, whereas Deactivated Affect was positively correlated with both Social Desirability and Life Satisfaction. After reporting (in the next two sections) preliminary analyses and results pertaining to job-related crucial variables, results obtained from analyses of variance of subjects' answers to emotion labour and the other psychological dimensions, and their relationship with job-related and other variables, are discussed.

Frequency and duration of interactions with patients, and time for listening to patients

Hospital operators reported an average of 19.0 interactions with patients per day (s.d =16.5), each lasting for 13.7 minutes (s.d.=10.4). In order to assess the variable 'Duration of interactions with patients', in addition to the total interaction duration in a day, we employed a measure of the time spent in listening to patients, that is, used for actual dialogue with patients. Employees could choose one of the following categories: 1 = less than 30 minutes (20.7% of operators), 2 = about one hour (30.2%), 3 = about two hours (26.6%), 4 = more than three hours (22.5%); mean value = 2.5(s.d.=1.1). Note however, it is difficult to measure adequately the duration of interactions with patients when using subjective estimates, because people themselves are likely to interpret the question in different ways. For instance, someone might include in this evaluation also time spent in health care actions not necessarily associated with a communicative interpersonal exchange, and that do not imply an actual relational contact (as exemplified by time an employee might spend in caring for a person in the 'reanimation' chamber, when dialogue with the patient is impossible), or that imply a 'varying within the interaction time' relational contact (as when a doctor is taking the blood of a donor, or medicating a patient). Such variations might be perceived differently by different operators. After a close inspection of results, the original frequencies of the total duration were re-coded into new values, descriptive of differential frequency ranges (see Table 15.2).

Pathology that employees were in contact with, and years worked

To better assess the impact of job-related variables, we took into consideration two other aspects. First, we were concerned with the presumed gravity of patients' pathologies that employees are in contact with. The hospital department or ward where employees are working might in fact be expected to be an important job-related variable: every ward is characterised by various working tasks and functions, working rhythms, as well as by the gravity or particularity of pathologies dealt with. It is plausible to think that working in some wards of the hospital is less exhausting than working in some other, as shown, for example, by comparing the maternity ward and intensive care unit. For this reason, the numerous wards of the hospital where data were collected were subdivided in three categories: wards characterised by short contacts (for example, analytic laboratories), medium pathology, and serious pathology (for example, intensive care unit).

The second variable we considered was the number of years employees had been working. Original frequencies were re-coded into two groups: *less than one year*, and *more than one year* (see Table 15.2).

Results of analyses of variance

To test differences between subject groups, a series of univariate analyses of variance were carried out. In these analyses, the original (interval, or categorical) scores of the variable hypothesised to differentiate between subjects, that is, assumed as an independent variable, were re-coded into two or more categories on the basis of their original score distribution. The results obtained from the set of analyses of variance (see Table 15.2) confirmed the correlational trends reported above. The results obtained by the analyses of variance (we report only those that obtained significant effects) showed direct effects due to the kind of ward on Emotional Exhaustion, Depersonalisation, and Work Realisation. Employees who were working in serious pathology wards reported a greater sense of emotional exhaustion and depersonalisation than their workmates, but, interestingly, also reported a greater work realisation. The kind of ward had no significant effects on *Emotional Labour*.

Employees who were engaged in the lowest number of interactions (from one to five) were characterised by the highest rating on the *Depersonalisation* dimension. This result can be interpreted as an indication that depersonalisation acts as a coping mechanism, implemented to protect against fatigue. When frequency of interactions was extremely high (more than 21, the highest) employees reported the lowest rating on the

Table 15.1 Means of, and significant correlations between, main subjective dependent variables

	DA	EC	EE	DP	WR	JIN	PA	NA	DAf	SD	LS	% Var	Mean
Surface Act.SA	-----	-----	.31 b	.21 b	-----	-----	-----	-----	-.23 b	-----	-----	31.0	2.13
Deep Act. DA	***	-----	-----	.15 a	-----	-----	-----	-----	-----	-.26 b	-----	12.9	2.81
Emotional Cons.EC		***	-----	-----	.43 b	-----	-----	-----	-----	-----	-----	13.7	3.84
Em. Exhaust. EE			***	.26 b	-----	-.22 b	-.21 b	.17 a	-.44 b	-----	-.17 a	21.8	2.59
Deperson. DP				***	-----	-----	-.19 a	-----	-.25 b	-.40 b	-----	12.1	1.55
Work Realis.WR					***	.21 b	-----	-----	.21 b	-----	-----	12.3	3.59
Job Involv. JIN						***	.17 a	-----	-----	-----	-----	41.6	3.50
Pos. Affect PA							***	-----	.19 a	-----	.32 b	18.4	3.26
Neg. Affect NA								***	-.38 b	-----	-.41 b	15.8	1.79
Deact. Aff. DAf									***	.20 b	.39 b	25.2	3.41
Social Des. SD										***	-----	24.7	3.45
Life Satisfact. LS											***	69.8	4.06

Probability: $^{a}p<.05$; $^{b}p<.01$; $^{c}p<.001$; $^{t}p<.10$

% Var: Percentage of variance explained by the dimension (sub)scale;

Emotional Labour, Maslach Burnout Inventory, and Frequency of Affect were measured on a 5-point scale (1=Never; 5=Always)

Job Involvement, Social Desirability, and Life Satisfaction were measured on a 6-point scale (1=Disagree; 6=Agree)

Table 15.2 Effects of independent variables on Emotional labour, and on other variables

	Hospital Wards				**F**
	Short Contacts	**Medium Pathology**	**Serious Pathology**		
Emotional Exhaustion	2.35 a	2.79 b	2.44 c		4.85b
Depersonalisation	1.73 a	1.55	1.44 b		3.61*
Working Realisation	3.36 a	3.64 b	3.73 b		7.23***
	Number of Patients				
	1-5	**6-15**	**16-20**	**>21**	
Depersonalisation	1.77 a	1.52	1.43 b	1.60	2.93*
Job Involvement	3.69 a	3.70 a	3.51 a	3.10 b	3.69*
	Duration of Interaction				
	1-5 min.	**6-10 min.**	**>11 min.**		
Working Realisation	3.41 a	3.60 b	3.74 b		6.48**
	Time for Listening to Patients				
	< 30 min.	**1 hour**	**2 hours**	**>3 hours**	
Surface Acting	2.11	1.82 a	2.20 b	2.30 b	3.8**
Deep Acting	2.94 b	2.98 b	2.27 a	3.03 b	3.47*
	Years in Job				
	< 1 year	**> 1 year**			
Surface Acting	1.95	2.21			4.13*
Emotional Exhaustion	2.42	2.67			4.17*
Depersonalisation	1.43	1.59			4.11*
Social Desirability	3.71	3.36			6.92**

Probability: *= <.05; **= <.01; ***= <.001

The letters *a*, *b*, *c*, next to the means indicate the results of post-hoc analyses

Job Involvement scale. Results about the duration of interactions showed the same trend: employees who have the shortest-lasting contacts with patients reported the lowest Work Realisation. Operators who spent much time listening to patients (more than three hours) were characterised by the highest frequency of *Surface Acting*. Finally, employees who had been working longer than one year were characterised by a higher frequency of *Surface Acting*, showed higher ratings on the Emotional Exhaustion and Depersonalisation dimensions, and reported lower Social Desirability scores.

Social desirability bias: a note of caution

As mentioned earlier, to test for potential biases in the obtained self-reports, employees were asked to complete a Social desirability bias (SDB) scale, a short version composed of eight items, rated by subjects using a 0–5, False-True scale. Factorial analyses showed that five out of the original eight items could be retained, all of which dealt with the attribution to the self of positive traits, such as 'No matter whom I am talking to, I am always a good listener'. To test more precisely for Social Desirability bias effects, a multivariate analysis was carried out on re-coded SDB scores that subdivided subjects in high and low proness to Social desirability biases: HSDB = employees with a mean score above the sample mean; LSDB = employees who were below the sample mean. The results confirmed that, in comparison to LSDB employees, HSDB subjects expressed lower Emotional Exhaustion than LSDB subjects (2.43 vs 2.75, respectively, $p = .008$), and lower Depersonalisation (1.37 vs 1.73, respectively, $p = .0001$). HSDB subjects tended to report more frequently Positive Affect (3.39 vs 3.13, respectively, $p = .034$), and Deactivated Affect (3.60 vs 3.23, respectively, $p = .005$), and a higher sense of Working Realisation (3.68 vs 3.49, respectively, $p = .009$).

Conclusion

Results of this study leads us to conclude that emotional labour is a very important aspect regarding the psychophysical wellbeing of hospital employees whose job demands interactions with patients. *Surface Acting* (modifying facial or other external expressions) and *Deep Acting* (modifying inner feelings) was found to constitute an independent dimension of emotion regulation, a dimension that specifies on what objects the regulation acts, and thus, to some extent, indirectly measure the nature of the activated regulatory processes. *Emotional Consonance*, a third dimension obtained in this study, reflects the extent to which regulatory processes are called for in that it denotes the extent to which an employee feels job-congruent emotions. The consonance dimension (in previous studies on emotion labour it was referred to differently, including the term 'genuine emotions') exhibited no relationship with the regulation dimensions. In other words, although an employee often effortlessly feels job-congruent emotions, he/she might also feel job-incongruent emotions that also needed to be regulated.

Some job-related independent variables were shown to be important in defining the extent to which employees perform emotional labour, and how they feel about their work. In particular, considering the duration of interactions, it is interesting to note *Surface* and *Deep Acting* seem to be directly related to the *time for listening patient variable*, whereas the *total duration of interaction*, does not appear directly related with the regulation modalities. In fact, a plausible hypothesis is that when the employee is engaged in a communicative interpersonal interaction he/she gives more attention to its emotional atmosphere. This attention requires emotional effort. The other job-related variables we considered, that is, the kind of ward, the number of patients, the duration of interaction and the number of years the employees have been working, do not appear to be directly related to emotional labour (with the exception that *Surface Acting* is directly related to job experience, measured by the number of years a worker has spent working), whereas they are directly associated with the various dimensions of *Burnout* (Emotional Exhaustion, Depersonalisation and Work Realisation).

In conclusion, emotional labour has significant implications for employees' wellbeing. Emotional regulation of inappropriate emotions imply effort, that is, if the person feels inappropriate emotions she/he will spend psycho-physical resources in order to deal with this state of affairs. If emotional labour is too frequent, or it is of an 'inadequate' variety, it might have psycho-physical negative effects, such as inducing Emotional Exhaustion and/or Depersonalisation and, indirectly, lowering a person's overall sense of life satisfaction. In fact, the pattern of correlational results showed *Surface Acting* is negatively associated with Deactivated Affect, itself related to Life Satisfaction. In other words, we could conclude that quality of life is associated directly or indirectly with the absence of negative and dissonant feelings, with the presence of job consonant emotions, and with affects that denote calmness and serenity – an essential component of working life.

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16 Work in the trenches: fear and anxiety in the workplace – an exploration

Monica Leon

This chapter presents a discussion on the relevance of fear and anxiety in the workplace. A review of selected literature is presented, including two interdisciplinary definitions of fear and anxiety. The similarities and differences of these in terms of both antecedents and dynamics are explained. My exploration demonstrates these two emotions can have a counter-productive impact if not managed appropriately, either paralysing organisations or rendering them 'dead in the water' before they have a chance to confront and manage the situation.

Introduction

Fear and anxiety are an integral part of the workplace. However, an increasingly pervasive trend in modern organisations is a persistent fear of everything or everyone at work, creating new environments dubbed 'quiet war zones' (Goleman, 1998). These two actors are infamous – 'infamous' because both have been perceived as hindrances to the achievement of organisational goals (Suarez, 1994, 1996; Ryan & Oestreich, 1998; Senge, Kleiner, Roberts, Ross, Roth & Smith, 1999; Gettler, 2000). From a psychological point of view anxiety and fear are considered *negative emotions*, because when experienced to an intense degree, they can be very distressing and have a negative impact on the physiology of an individual. Statt (1994) presents what maybe considered an extreme view regarding the impact of psychological thought on physiological health when he writes:

> *There is a growing school of psychological thought, which believes that all physical illness is also psychological to a greater or lesser extent. If we accept this hypothesis it would mean that virtually all absences from work which are attributed to ill health - other than occupational hazards... – have been psychologically caused. That is, for all practical purposes 'health' in the workplace means mental health (p85).*

Similarly, a recent report from the International Labour Organization

(ILO) studied the topic of mental health in the workplace across five countries: Finland, Germany, Poland, United Kingdom and the United States. The report identifies that as many as one in ten workers are suffering from work-related mental illnesses that in some cases have led to unemployment and even hospitalisation. Work-related mental illness is a product of *anxiety*, depression, stress and/or burnout. The direct impact on employers is reduced productivity and the cost of recruiting and training replacement staff. The study estimates that the total cost at a national level is between 3% and 4% of the European Union's GNP and approximately $30 to $40 billion in the United States (Gabriel & Liitmaitainen, 2000).

The figures above do not necessarily reflect that there has been an upsurge in the number of cases of mental illness. The impact on total costs may be at least partially attributable to other factors such as changes and advances in the diagnosis of mental illness, a rise in the number of reported cases due to better diagnosis, recognition of symptoms, and a greater willingness from those suffering from mental illnesses to seek help when needed. Nevertheless, experts estimate at any given time approximately 20% of the adult population is suffering from a mental health related illness (Gabriel & Liitmaitainen, 2000).

Employees who have suffered a mental health problem, such as burnout or depression, and decided to take medical leave are faced with a number of difficulties when re-entering their workplace. These difficulties relate to the social stigmatisation of mental health problems. For example, there is a risk bosses and co-workers will have changed their perceptions of the professional capabilities of the employee. When confronted with this prospect many employees prefer to opt for early retirement or a disability pension. This creates economic pressure not only at the organisational level, but also at the societal and the individual level. It is important to note long-term mental health difficulties are, according to the World Health Organization, one of the three leading health disorders globally, and a major reason for the granting of disability pensions (Gabriel & Liitmaitainen, 2000).

Not all countries approach this issue similarly. For example, in the United States employers are beginning to address it by educating their workforces about mental health issues. The ILO report estimates 40% to 60% of US workplaces with more than 50 people offer some type of mental health program, such as stress management. In other countries, such as Germany, the promotion of successful stress reduction programs is becoming commonplace. These programs include education in relaxation techniques, and role-playing and behavioural training to increase self-confidence and improve interpersonal skills.

Clearly, there may be a number of different risk factors contributing to the development of mental ill health by an employee, such as heredity and personal circumstances. However, it was found in all five countries covered by the ILO study that the effects of job stress are ranked among the most common work-related health problems (Gabriel & Liitmaitainen, 2000).

The leading indicators of work-related stress – or *unresolved anxiety* (De Board, 1977) – are lack of job security, time pressure and lack of opportunity for career development. In addition the ILO report identifies the overemphasis on results (bottom line), the blurring of boundaries between work and private domains, overload, and the unpredictable nature of job requirements as the main negative side effects of recent changes in the labor market, such as restructures, downsizing, mergers and acquisitions. Organisational downsizing and an ever-growing number of change initiatives in the workplace can be added to the picture.

De Board defines stress as unresolved anxiety (1977). Using this working concept, workplace initiatives such as stress management or the provision of new learning opportunities are little more than prescribed palliatives for organisations in emotional turmoil. At the right level stress can be motivational - but too much of it for too long can trigger problems with mental and physical health, particularly over extended periods.

A 'common' approach suggested by some authors is that fear and anxiety be driven out, eradicated or eliminated from the workplace at all costs (Suarez, 1996; Ryan & Oestreich, 1998). Others suggest fear can be effective in improving performance, because it keeps the workforce on its toes (Alonzo, 1998, p28). The practice of 'management by intimidation' (Bruhn, 1996 p29; Appelbaum, Bregman & Moroz, 1998), which creates environments rife with fear and anxiety, is an example of such a school of thought. However, a few authors (Voyer, Gould & Ford, 1996; Senge *et al.*, 1999) have acknowledged that fear and anxiety are part of the original cast of actors within an organisational context, and here to stay, and that their nature - evil or good - is determined by how the organisation acknowledges and manages them. It is now understood organisations are 'emotional arenas' (Fineman, 1993, p9) that shape and are shaped by and through, the interaction of the people who work in them.

Against this backdrop, I now concentrate on fear and anxiety as the two emotions I believe to be the root cause of the malaise of mental ill health in the workplace. My main thesis is that a better understanding of fear and anxiety is paramount in enabling workplaces to fight fear and anxiety from within, as it will equip those who work with better tools to deal with these pressures. Understanding may lead to better managerial practices that will in turn translate into a healthier workforce. A review of some of the literature contributing to the present body of knowledge about these two emotions follows.

Fear

While authors from various schools of thought may differ as to the precise physiological or psychological definition and composition of fear, I suggest an integrative and interdisciplinary perspective for the purposes of this paper. Most authors agree fear is an emotion that arises as a response to real threat (Gray, 1987; Doctor & Kahn, 1989; Dozier, 1998). In fact, Dozier (1998) says fear is a safety mechanism that keeps us out of harm's way by helping us avoid pain and its consequences, such as injury and death. Fear is not only a normal emotion, it is also a very useful one, and it is considered an appropriate response to a concrete real and knowable danger. Fear as an emotion has also evolved to keep us safe from psychic pain, such as humiliation, sorrow, regret, guilt and despair (Dozier, 1998). Research has shown physical and psychic pains have the same physiological impact on the human body. Contrary to popular belief, fear can also motivate learning and the performance of socially useful responses such as careful driving, completing an examination in school or learning new things (Schein, 1994; Dozier, 1998).

It is then quite puzzling to find modern management literature suggesting fear be eliminated from the workplace (Suarez, 1994, 1996; Ryan & Oestrich, 1998; Gettler, 2000). Fear is an endemic human condition that is part of the basic repertoire of emotions resultant of 'a state of the brain, or neuro-endocrine system, arising under certain conditions and eventuating in certain forms of behavior' (Gray, 1987, p3). Moreover, human beings have had to deal with and manage their own fears for many years, as was pointed out by Darwin in his 1872 classic, *The expression of emotions in man and animals:*

> ... fear was expressed from an extremely remote period in almost the same manner as it now is by man...' (as cited in Dozier, 1998, p5).

On the other hand, just as fear can keep us safe and act as a motivator, it can also impact on us negatively. Psychologists have labelled fear a *negative* emotion inasmuch as it can have a damaging effect on our physiology

(Siminov, 1970; Statt, 1994; Strongman, 1996). So the questions are: When does fear change from a useful emotion into a harmful one? and Why does this occur?

It is suggested fear may become chronic. At this stage it causes a variety of unpleasant feelings including terror and a desire to escape, and induces certain types of behaviours such as flight, fighting, or concealment. Other symptoms of chronic fear include fatigue, depression, slowing of mental processes, restlessness, aggression, loss of appetite, insomnia and nightmares (Doctor & Kahn, 1989). Given these potential symptoms it is understandable that organisational researchers may want to drive fear out of the workplace (Suarez, 1994, 1996; Ryan & Oestrich, 1998; Gettler, 2000). However, as already mentioned, fear cannot be driven out of the individual, as it is an inbuilt emotion in all of us.

The definitions of fear as a 'reaction' and 'response' to 'real threat' may imply that fear is a knee-jerk process inevitably triggered every time we perceive a 'real threat'. Fear is a complex system, with three interconnected mechanisms that work in parallel to produce the emotion: the primitive fear system, the rational fear system, and consciousness. Each system is more sophisticated than the other in the way it chooses to deal with the threat, and each functions as gatekeeper for the others, by reassessing the sensory pictures sent to the cortex (Gray, 1987; Dozier, 1998).

The fear system operates under models generated at the consciousness level. The complexity of consciousness is evidenced by its pervasive state of alertness and the ways in which it continually reads external threats – modelling, adding and subtracting variables and factoring responses to them. This is a continual process that works over laborious hours, months, and years, continually shaping and re-shaping its models. Dozier (1998 p12) suggests the huge range of fears one may experience flows from the complex model of the world we carry with us. *Consciousness* is what he calls the 'supreme decision maker' and the 'supreme defensive system'.

From the totally different perspective of learning/behavioural theory (Gray, 1987) one can learn that even though fear occurs as part of an innate and involuntary mechanism that signals danger, these signals can be learned, unlearned or conditioned. Strongman (1996) explores the early 20th century work by Pavlov and Watson into how punishment works, which demonstrated how fear can be attached to a previously neutral stimulus (non-life-threatening) to motivate or reinforce responses (Strongman, 1996). This not only corroborates neuroscience's findings but also enhances our understanding about how we learn to fear.

In light of what neuroscience has to tell us about how consciousness shapes our 'fear models' by constantly scanning and reassessing environmental threats, plus what learning/behavioural theory tells us about how fear can be learned, unlearned or conditioned, we can conclude that from an organisational point of view, fear can be managed.

Two general variables influence the level of fear a person experiences. The first is the nature of the threat and the sense of helplessness or loss of control we may experience in a frightening situation (Dozier, 1998). This has implications for organisations in terms of how problems or potential dangers are framed and resolved, as well as the span of control individuals feel they have over their destiny in connection to the perceived 'real threat'. The second is the processes of sensitisation and habituation that shed light on how some managerial practices can become counter-productive. For example, reminding employees of threats or potential dangers once in a while will sensitise them, but doing it continuously may habituate them (Gray, 1987; Dozier, 1998). The difference is that while sensitisation makes the individual aware of the danger, habituation makes the threat a common event of daily life.

The problem with this is that some individuals may lose the ability to habituate. This causes them to live in constant fear and prevents them from functioning normally. Habituation seen in this respect is a component of learning, for example hypochondriacs have lost the ability to habituate minor illness (Dozier, 1998) perhaps as a result of magnifying or aggrandising what may be considered a minor illness. At this point, fear becomes destructive and unmanageable from an organisational point of view. However, a series of mechanisms, such as educational programs, can be put in place to recognise the antecedents of fear as a disease.

From a sociological point of view, Glassner (1999) tells us through well-documented research that there is a growing culture of fear, where perceived real threats are really just the magnification of selected facts. The key is to be able to distinguish between 'real or valid threats' and the 'false and over drawn fears' that cause a disproportionately overbearing emotional burden. Of course on a day-to-day basis, one is routinely presented with 'selective', 'incomplete' or 'speculative' views about a different range of topics that may induce fear (Glassner, 1991, pxv).

Each school of thought has provided a particular view of what fear is and how it works. They stand apart from one another without breaking inter-disciplinary boundaries. I believe these views or perspectives are complementary rather than mutually exclusive. To summarise thus far: fear is a complex emotion arising from perceived threat or danger. However, it is an appropriate response only in the face of a concrete or real danger. Just as fear can be learned, it can be unlearned or re-framed either by the natural process of habituation or by consciously exploring what is termed our own 'fear models'. Giving people more control over the outcomes they perceive as threats can also reduce the type of fear causing distress. From this perspective fear can be managed in order to diminish its negative impact in the workplace.

Anxiety or angst

Of all emotions, anxiety poses the biggest challenge to formulating an integrative perspective. Strongman (1996) says anxiety is the most researched of all specific emotions and has been the most theorised. Most research on the topic has remained school-specific, and seldom crossed pre-established disciplinary boundaries. A brief and selective summary of theories enhancing our understanding of organisational life follows.

One of the greatest hurdles to overcome when scanning the literature is grasping how anxiety has been conceptualised. Schools of thought such as psychoanalysis refer to fear and anxiety as one emotion, fear being a type of anxiety. For instance, Freud makes a clear distinction between what he called realistic or objective anxiety and neurotic anxiety (De Board, 1977; Strongman, 1996). Objective anxiety is fear for the purposes of this paper, while neurotic anxiety or anxiety responds to unconscious or unrealised threats as its source. Doctor and Kahn's (1989) definition complements Freud's definition inasmuch as it recognises the physiological symptoms that accompany the unpleasant feeling of apprehension, often of unknown origin.

The difference between anxiety and fear seems then to be rather straightforward, fear stemming from external threats, while anxiety responds to internal or unrealised threats. However, Dozier (1998) suggests the difference between fear and anxiety is the time lag differential that each emotion addresses. Fear addresses the present real danger, while anxiety addresses events in the future. Moreover, Menzies (1960) suggested that in cases where the levels of anxiety are not tolerable, there is a reversion to infantile fantasies of the past. It is then logical to conclude, due to its unconscious nature, anxiety may at this stage be unmanageable.

To test the first assumption we turn to Freud. He conceptualised anxiety as either inherited or learned at birth, without closing off the possibility there could be later additions as time went by (Strongman, 1996). From the physiological point of view, Gray (1987), Dozier (1998) and Goleman

(1998) suggest all individuals may have a natural imprint regarding tolerance to certain emotions such as anxiety and fear. From cognitive theory, Eysenck (1988) goes on to say the physiological system is connected to the cognitive system, and if we are to consider anxiety we need to look at both systems working together (Strongman, 1996). He argues there is high and low trait anxiety in *the information* an individual may store in his or her long-term memory. Mood also has a strong influence on that information. Strongman says:

> This memory approach to trait anxiety also helps to account for changes in trait anxiety that occur over time and also to deal with the fact that some are anxious in some stress-producing situations but not in others (p.167).

Even though anxiety tolerance may be seen as wholly deterministic due to its natural imprint, and unmanageable due to its causes, it is debatable that it cannot be diminished. If we follow Eysenck's (1988) theory of trait anxiety, we can see this high or low tolerance to anxiety can be aided by the ways in which we frame our experiences. Furthermore, we know from a sociological point of view that individuals do not live in a social vacuum (Watson, 1997). Fineman (1993, p10) says that for social constructionists 'reality and its expression is a product of interacting individuals'. As has been suggested in some managerial textbooks (e.g. Fulop & Linstead, 1999) it is the role of the organisation to create appropriate frameworks for organisational and individual development. One can then conclude an organisational intervention that may influence the frameworks in a positive way may contribute towards lowering levels of anxiety.

Staats & Eiffert (1990) aid our understanding of anxiety by adding a different perspective on its formation and tolerance through their multilevel behavioural theory. They said it is not necessary to have had a traumatic experience in order to develop anxiety, but that it can result from negative emotions associated with particular situations. In this case, anxiety is a type of self-conditioning (Strongman, 1996). If it can be self-conditioned, individuals can prevent the escalation of their own anxieties.

Anxiety as portrayed above can be seen as cumbersome but manageable. However, this operates under several assumptions: that the sources of our anxieties are known to us, that our anxieties only impact on us with a wary sense of uneasiness, and that we can use ourselves and the workplace as a filter mechanism to diminish anxiety. In fact, object relations theory highlights that people use one another to stabilise their inner lives (Hirschhorn, 1990). Moreover, Jacques (1955) said that the main reason why people began to group and work together in organisations was to defend themselves against their own individual anxieties.

A concept used as a framework to explain the dynamics of how anxiety works within individuals, groups and organisations (Hirschhorn, 1990; Krantz, 1996; Voyer, Gould & Ford, 1996) is the manic defense mechanism, proposed by Klein (1957) and later expanded by Bion (1961). This psychodynamic process combines the splitting, projection and introjection of the source of anxiety. The good and the bad are split – the individual introjecting the good, and projecting the bad onto another person or group. For instance, supervisors who are anxious about meeting a deadline may see themselves as doing their best to accomplish the job, while perceiving their employees as lazy and deserving to be punished.

The drawback of this conversion from internal to external threat is that if the fear system misreads the sensory data it will incorporate this new fear into the consciousness model. This conversion from anxiety to fear prevents us from dealing with the source of our anxiety, and therefore there is no identification or it remains unresolved. To make the topic more complex, a study by Jacques (1955) illustrated other nuances and variances to this defense mechanism. Either by unconscious selection or by choice, the individual who was subject to the 'bad internal objects' of others introjected this projection, making it their own. This mechanism allows unconscious anxieties connected to the real source to remain unexplored, whilst creating an *organisational bogeyman*, for example, the first officer of the ship who is seen by the crew as the source of all problems, including those things for which he is not directly responsible (De Board, 1977).

A variance of the same manic defence mechanism is the process of *idealization, splitting and denial* (Jacques, 1955). In this case the good and bad aspects are split, idealising the subjects of our projection into something they are not. By denying that others have any negative aspects, we protect ourselves from our own reflections – the fact that we may have negative aspects. Even though in this case our anxieties have not been converted into 'objective threats' or fear, their source remains unresolved, while we act in a context that bears little resemblance to what is actually happening. This is a matter of particular concern in an organisational context, as the organisation may be addressing issues and solving problems out of context, while the real problems remain hidden and unresolved.

It is suggested real group development occurs when the group learns by experience in greater contact with reality and that to a certain extent 'administrative and managerial problems are simultaneously personal and interpersonal problems expressed in organisational terms' (De Board, 1977, p37).

Fostering experiences that allow people to test their assumptions as well as face reality has important implications for how we manage people. Sheltering employees from 'bad or painful news' may not be helpful at all. In fact, employees need to face reality in order to come to terms with the sources of their anxiety. The idea of withholding information that may impact the employee's future poses more than an ethical question, as it has a direct impact on the emotional development or regression of the employee. Open communication in this case will bring anxiety of its own, however it lets employees work through the threat and actually ascertain the level of real threat (fear) that this represents to them.

In her study of nursing practices in a British hospital, Menzies (1960) described how organisations enacted social defence systems to avoid anxiety. In an environment such as this she found the nurses were not able to cope with a high degree of anxiety. Menzies observed a number of the hospital's practices were not necessarily aligned with goal effectiveness - in this case doing what was best for the patient. Firstly, nurses engaged in a series of practices not aligned to this goal; for example, the rotation of nurses in and out of wards, and waking patients in the middle of the night to give them medication. It became apparent these practices aimed to prevent nurses becoming too close to their patients, in order to minimise effects of anxiety produced by working with sick and dying people.

Unfortunately, the job rotation strategy itself created an escalation of anxiety, as the nurse was routinely confronted with new tasks, supervisors, patients and other sources of anxiety. This social defence system, enacted to alleviate the primary anxiety, succeeded only in creating secondary anxiety, thereby diminishing the level of neither. Menzies (1960, 1988) suggested the nurses' continuous exposure to this anxiety-prone environment forced them to emotionally regress to a 'maturation level' below the one they possessed before joining the organisation. Thus, the hospital system negatively impacted on their emotional development. Menzies believed the hospital failed to equip the nurses with ways to recognise and deal with their anxiety. Again, facing reality is the only cathartic point in resolving or working through our anxieties.

Moreover, these social defence systems have an impact on the structure and culture of the organisation (Jacques, 1955; Menzies, 1960, 1988). Hirschhorn (1990) suggests bureaucratic practices are also disguised forms of social defence, for example excessive checking and monitoring to reduce the anxiety of making difficult decisions by diffusing accountability. This may be a possible reason why bureaucracy, in spite of its numerous detractors, remains a central feature of many organisations.

The concept of social defence mechanisms at the organisational level begs the question of why they are enacted in the first place. In a pilot study on residential institutions for the physically handicapped and children who were chronically sick, Miller & Gwynne (1972) found the 'implicit' task given by society to these organisations was beyond their reach (De Board, 1977). The lack of congruence in the inbuilt requirements, and the high aspiration level of the organisational goal, which went far beyond what could be considered practical or realistically deliverable, led them to enact defence mechanisms to deal with their anxiety. Miller & Gwynne's findings are relevant in terms of re-examining organisational practices such as individual performance management programs, goal setting and organisational development strategies.

Literature on learning provides ideas about how reality can be used to reduce anxiety. For example, scenarios of disaster may be motivating in the short-term, but in the long term only raise anxiety to a level that is prejudicial to the individual and the organisation (Schein, 1994). Schein suggests positive visions of self and others reduce this type of anxiety. This complements what Eysenck (1988) says about anxiety being connected to mood and how we frame the perceived threat when it's stored in our long-term memory.

Our understanding of anxiety would remain handicapped if we chose one particular line of thought among the different disciplines, rather than attempt a comprehensive view of it. I believe fear and anxiety can complement each other by providing a fuller picture and are not mutually exclusive of one another. Anxiety is a complex emotion, and its source is not always known. There are several inbuilt coping mechanisms that help us deal with anxiety by transforming our sense of unease into a real threat. Under the 'real threat' mode, or the emotion of fear, what's causing the fear (object) can be re-examined to validate its real danger or threat. Like fear, anxiety can also function as a motivator. Unlike fear, 'anxiety memories' rely heavily on the connection to a person's frameworks or moods at the time at which they were stored. The problem is that unlike fear, the 'sources or causes' of anxiety memories tend to remain largely unexplored.

Because social defence mechanisms can be enacted at the organisational level, it is imperative for organisations to re-examine the assumptions under which they operate. From this perspective anxiety, as well as fear, can be managed in order to reduce its negative impact in the workplace.

Anxiety and fear

Apart from the psychoanalytic studies (Menzies, 1988; Hirschhorn, 1990; Ketz Van de Vries, 1991) in which anxiety has been studied with precision and detail, the concepts of fear and anxiety have been used loosely and equated or amalgamated to create a new emotion: 'fear-anxiety' (Bruhn, 1996; Suarez, 1996; Alonzo, 1998; Appelbaum, Bregman & Moroz, 1998; Ryan & Oestreich, 1998; Senge *et al.*, 1999). The words 'anxiety' and 'fear' have also been used interchangeably at times not only by laymen but also, for example, by early learning and behavioural theorists to explain punishment and conditioning. Some commentators have viewed anxiety as the main emotion, fear becoming a sub-set reaction to an objective threat (Freud, 1917, 1926). Others, such as Dozier (1998) feel that fear is the core emotion and anxiety is the sub-set emotion that shifts into gear at the prospect of future threats. While fear and anxiety may have similar implications, they differ in terms of both their antecedents and dynamics. To illustrate this, I have created a chart that systematises the different propositions put forward about these two emotions, giving a broad definition of what fear and anxiety are and how they operate.

Much of what has been written about anxiety and the workplace stems from the modern object relations theory, which highlights how people use each other to stabilise their inner lives (Hirschhorn, 1990). The manic defence mechanism, which combines the psychodynamic process of splitting, projection and introjection proposed by Klein (1957) and Bion (1961), is quoted repeatedly and used as a framework to explain and describe the dynamics of how anxiety works within individuals, groups and organisations (Menzies, 1988; Jacques, 1955; De Board, 1977; Hirschhorn, 1990; Krantz, 1996; Voyer, Gould & Ford, 1998).

The psychoanalytical approach to organisations has been mainly, and understandably, descriptive rather than prescriptive. In other words, there is a dearth of empirical research on organisations dealing with the ad-hoc management of anxiety. The study of fear in organisations has remained part of the realm of psychological studies at the individual level. Most literature on fear comes from methodological behaviourism, which observes behaviour from a psychological point of view, and ethology, which studies the behaviour of animals (Gray, 1987). Lately this literature has also been enriched by the observations of neuroscientists. Nonetheless, the psychoanalytical writings show how anxiety blocks progress towards the fulfillment of organisational goals.

The literature presented here has shed different lights and enriched basic understanding of the two emotions, fear and anxiety. This somewhat kaleidoscopic view of them may allow us to find different points of leverage and intervention in an effort to minimise their negative impacts on organisations and those who work in them.

Workplace health promotion approaches

Literature on human resources management and employment relations cautions that uncertainty in the workplace may foster fear and anxiety for both employees and employers. The nature and complexity of jobs have changed so dramatically in recent years it can be expected employees will probably feel more insecure and threatened in the job arena. Fear and anxiety reactions can arise in an employee due to a very real shortfall in job competence, or from an inability to learn. Compounded with this, organisations are undergoing rapid change in order to survive, and this can be threatening to some employees.

One cannot deny that uncertainty is a feature of post-industrial society. Even the very perception that people are more frightened than ever today has its own power, because it does influence behaviour (Gettler, 2000). Indeed, the challenge posed by fear and anxiety may well be the most frequently faced and most difficult to overcome in sustaining profound change (Senge *et al.,* 1999).

It is not surprising then, that organisations and their members continue to create mechanisms to cope with long-term unresolved anxiety, as well as with real threats to survival in the marketplace and job arena. A case in point is the newly defined managerial role of so-called 'toxic handler' (Frost & Robinson, 1999, p97). A toxic handler has the unofficial role of emotional counsellor, helping other employees work through their emotional turmoil and pain. It is uncertain whether those employees who take on this unofficial role make the decision to do so consciously or unconsciously. However, clearly they perceive a need to take it on in order to facilitate the accomplishment of a goal or task at hand.

This ad-hoc toxic handler role is not free from hazard. In some cases, they pay a high emotional and physiological price. They may suffer from such conditions as ulcers, heart attacks, burnout and depression as a result of intense and prolonged exposure to unresolved anxiety, lack of adequate skills in distancing from other people's problems, lack of self-awareness of their fears, and an insufficient tolerance threshold for their own unresolved anxieties (Frost & Robinson, 1999). At the end of the day, the efforts of toxic handlers are at best an amateurish attempt to exorcise fear and anxiety from the workplace. This begs the question: 'What are organisations doing, in order to win or make their businesses thrive, by killing their own in the process?'

Organisational practices, such as stress management courses and the protection and deliberate propagation of toxic handlers, are merely palliatives, rather than solutions to the root problem. They function as security blankets, allowing organisations to feel safe from harm for a limited time. However, this illusion of safety is blocking the emotional development and mental wellbeing of many employees and organisations.

It is said a sign of mental health is the ability to tolerate uncertainty. However, the question of how to develop this tolerance and to act and feel in control, even in the face of uncertainty, remains unanswered. It is important to remember both anxiety and fear share a common gauge system – confronting reality – that suggests the development of self-awareness in individuals may be a useful strategy. Furthermore, the teaching and development of critical thinking processes that go beyond the rationalisation of problems may become another point of leverage.

The development of critical thinking skills may give individuals increased awareness of their surroundings, their own thoughts, biases and mental frameworks, and also allow them to become more discerning in terms of the 'reasonableness' of the propositions put forward (Ruggiero, 1997). These propositions may sometimes, if not contemplated from a critical standpoint, lead us into fear mongering:

> The tendency to trivialise legitimate concerns even while aggrandizing questionable ones (Glassner, 1999, p9).

The ultimate result may be the creation of panic-driven organisational cultures.

Some fears and anxieties may be put to rest by testing assumptions via the practice of dialogue. According to Isaacs (1999):

> The intention to dialogue is to reach new understandings and in doing so, to form a totally new basis from which to think and act (p19).

At the organisational level, this may imply the systems, policies and procedures under which organisations operate need to be revised, not through efficiency or value added measures, but through new measures that view organisational development from a more holistic perspective.

The end effects of fear and anxiety in the workplace may be organisational paralysis, restless and potentially futile (re)action, or, ulti-

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mately, organisational death before the situation can be confronted and managed. In this sense, fear and anxiety are not topics of interest for psychologists, ethologists and neuroscientists alone, but also for organisational researchers.

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..DO YOU HAVE HOW TO RELIEVE ANXIETY IN THE POST-MODERN ERA FOR DUMMIES?
YES... BUT NOT UNDER THAT EXACT TITLE...

Section V

Work: people, places and processes

The writings throughout this book present the broad area of work in terms of being about *people, places and processes*, bringing together a diversity of theories and people from many different sectors. In this approach there are certain ideas and values which we believe are common across all of the writings in this final chapter which encompass two broad areas – those interventions which enhance workforce skill and wellbeing, and secondly, broader workplace strategies and approaches. What is also interesting is the way that all of these contributions consider the work/life divide.

Peter Waterhouse's poem *Press Operator* clearly provides a picture of the richness of thoughts of a process worker. The changing features in our workplaces such as flexibility in our working hours, sporadic contractual work, the technological means for us to work from a range of sites, including the home office, have also functioned to blur the contrived division between work and life.

Trevor Waring, and Daniel Nicholls and Bee Mitchell-Dawson explore the effects that training can have on enhancing the mental health and wellbeing in different workforces. Addressing the training needs in two distinct areas of service delivery, hairdressing and nursing, the authors identify the assumptions and paradoxes surrounding our understanding of what roles these workers really play as part of their work. In the instance of hairdressing, Waring suggests hairdressers are often, by virtue of the intimate service they perform, placed in the role of client confidante and gatekeeper of private client information, frequently with distressed or troubled clients. Waring proposes that training in basic counselling skills and referral information will provide a service and enhance the worker's ability to cope with the often stressful, intimate interactions involved in the extension of hairdressers' roles into their clients' daily lives.

Similarly, Nicholls and Mitchell-Dawson argue that changing employment conditions and demands upon mental health nurses have expanded greatly in modern mental health service delivery. They argue that shifts in focus from primary mental illness to management of behaviours displayed has resulted in ignoring the core skills of nurses in prevention and education, with consequent ill effects on the mental health of nurses themselves.

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To counter both education and service gaps, they argue for a model of clinical supervision and support which they believe will benefit the consumers of mental health nursing care, and strengthen both the resilience and coping of the nurses themselves.

Enhancing resilience and coping of a workforce in a climate of change and stress is also the focus of the next two writings by John Shephard and Nicole Highet, Karen Field and Elly Robinson. As regards workplace strategies, they take a more individualistic, psychological view of how an employee may actively reduce his or her stress levels, and perhaps by doing this may offset anxiety, depression or more serious sequelae. In both instances these programs are focused on empowering the individual.

Whilst technology is often considered a cause of workplace stress, Shephard introduces an innovative means of addressing the problem by adapting one of the tools of technology – the Internet. He describes the research and development phase of an Internet application which has been designed to provide health information, which, it is argued, overcomes significant known obstacles to health-seeking behaviours – namely divulging confidential information to a stranger, stigma and cost.

Highet and colleagues offer a workplace depression program from a population health perspective which provides health information and referral options to workers who may be experiencing the symptoms, and to staff who may be able, through an informed approach, to provide better support and flexibility towards co-workers in difficulty. However, to be successful such an approach needs to be a component of a whole of workplace strategy, in which there is a preparedness to examine organisational structures, practices and policies as well as current staff management and staff development practices.

The next four papers provide examples of broader workplace reorientation into mentally health-promoting environments through active policies and programs. The first paper by Stephen McKernon, Ruth Allen and Elisabeth Money bridges the divide between the interpersonal and the structural through the development of the New Zealand Mentally Healthy Workplaces Toolkit. This project, in its early stages, offers a first taste at the way in which workers, managers and communities conceptualise a 'mentally healthy workplace' and is based on initial market research which highlighted a range of troubling organisational, community and individual issues contributing to mentally unhealthy workplaces.

Anne Boscutti's paper examines staff wellbeing as a critical dimension of mental health promotion strategies for organisation and service development. Services for high-risk populations such as homeless young people are of particular interest in Boscutti's exploration, as are health-promoting schools. Common themes for success across the programs are strong commitment from the leadership and a capacity to address staff wellbeing within a holistic organisational approach. Boscutti ends with a salutary lesson – leadership commitment to staff wellbeing is fundamental to any service reorientation strategy, and must include overcoming prevalent organisational cultures of victim blaming and bullying. In a warning reminiscent of Turney's chapter on the professions and bullying in Section III, Boscutti draws attention to common management and worker attitudes which blame a co-worker (or indeed, a client) for not being able to cope. Failing to cope with highly stressful, often distressing work too often equates with personal failure and as a measure of personal competence. Without addressing these dimensions, such programs will fail both clients and workers alike, and are surely inconsistent with any concept of a mental health-promoting organisation.

The benefits of establishing a workplace health promotion program, which has the commitment of both workers and managers, is also reiterated in Ellis and colleagues' paper about establishing the Upper Hume Community Health Service Employee Health Committee. Initial attempts at establishing a top-down intervention which was underpinned by a traditional medical model, were soon exchanged for an Employee Health Committee which developed according to the principles and values of a social model of health. Ellis aptly describes the processes involved in reorienting the Community Health Service towards a mentally healthy workplace.

Leanne Luxford and James Nichol describe a similar process, commissioned by the Mental Health Foundation of New Zealand, of establishing a mental wellness program in an aged care facility in Auckland. Findings from a survey administered to staff had identified that poor communication, lack of formal support systems for staff to deal with personal or work-related problems and fragmented organisational culture contributed to a lack of mental health and wellbeing. Importantly, it demonstrates the value of democratic processes in bringing about health change along with the need for support from both top and middle management.

The challenges facing profit-making organisations balancing company and employee needs are described by Barrie Thomas and John Murphy in their elaboration of meaning and work in the context of The Body Shop philosophy. The Body Shop is often acclaimed as a model of socially responsible business. Whilst not articulated in terms of a model of social health, Thomas and Murphy document the ways in which the Body Shop recognises and attempts to balance the work/life divide. They cite a number of Body Shop initiatives such as the establishment of a childcare centre on site, encouragement of staff to attend personal development courses, and engagement in active citizenship programs which involve a voluntary community commitment in work time. All of these activities are measured in terms of a social and environmental audit undertaken biannually.

The explicit Body Shop corporate values of social responsibility, concern with human rights, valuing the environment and social justice issues, are common to any notion of a mentally healthy workplace. The Body Shop attempts, and sometimes struggles, to enact them because it is the right thing to do, rather than because it is a sophisticated understanding of health. We suggest we might all be steering in the same direction.

The Press Operator

(for my friends at P.J.K.)

The operator is punching out car parts in the Press shop.
His calloused hands move with grace, precision
and an economy of motion in an industrial dance
choreographed by Frederick Winslow Taylor.
The press provides percussion in monotonous rhythm.
His eyes dance too, constantly scanning the punch, the die, the automatic feed,
searching for 'slugs' or splits in the steel,
alert for anything out of the ordinary.
I don't want to distract him, the machine removes fingers
as easily as scrap. Yet he sees me and smiles,
points to his ears and then to mine,
I'm not wearing plugs like he is.
He frowns his disapproval with exaggeration,
wags his finger at me, skilled at communicating
with expression and gesture in a world where words are lost
in a violent cacophony which assaults the body –
I can *feel* the presses pounding
through the soles of my feet on the concrete floor.
I nod and wave agreement, I should put the ear plugs in
but I can't have conversations on the line wearing them
and I won't be here for thirty years
to inherit the industrial deafness
he suffers without complaint.

The pile of parts in the bin grows steadily.
What is he thinking about as he tosses the blanks into the bin?
Is he counting, striving for the five and a half thousand every hour,
like the supervisor said, thinking about lubrication, the viscosity of the oil,
getting a green ID card for his next bin?
Is he thinking about his children at school, or university;
working for their future in a cleaner, quieter world
where discussions about personal safety

concern lighting in the company car park?

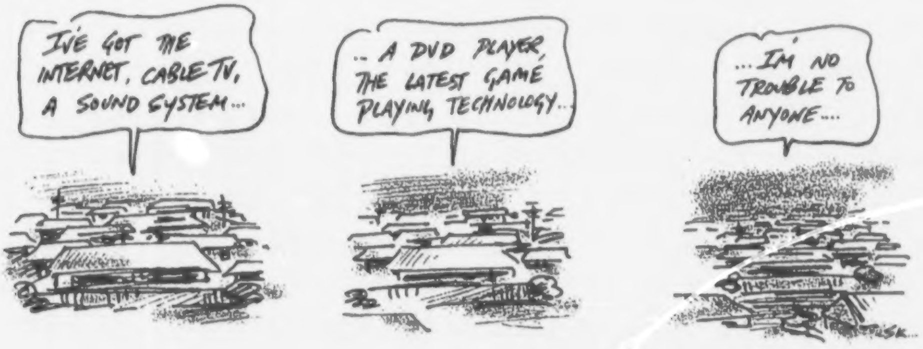
The safety guard closes on the press
and the ninety tonne punch crashes down
cutting and forming the metal blanks
just as it shapes the lives of its operators
with the full weight of its indifference.

© P.J. Waterhouse
April 1995

17 Using the Internet to empower individuals and organisations to combat workplace stress

John Shephard

The Internet is a potentially powerful tool in health care. Currently, most advances are in the areas of communications between professionals and medical record portability. There is, however, a growing demand by consumers for online health information. Emerging technology represents a potent opportunity for improving health outcomes. It is a new and persuasive way to communicate, disseminate information and empower individuals as well as communities. In the area of mental health, the ever-ready access of the Internet may be a way to overcome many of the obstacles currently confronting a sufferer. It does not require divulging personal information to a stranger, and may help overcome the significant barrier of stigma. It may also be more cost effective than current strategies. This paper is based on the research and development phase of a web-based program, called OneSmallStep, which has been developed with these opportunities in mind. The advantages of a broad approach to mental health promotion in the workplace are outlined, and the potential of the Internet for promoting mental health in the workplace is discussed. The Ottawa Charter, developed long before the wide adoption of information technology (IT) is used as a framework for the discussion.


I'VE GOT THE INTERNET, CABLE TV, A SOUND SYSTEM...
.. A DVD PLAYER, THE LATEST GAME PLAYING TECHNOLOGY..
...I'M NO TROUBLE TO ANYONE....
TUSK...

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Mental health in the workplace

How large is the problem?

High levels of stress in the caring professions have been recognised for a long time. A recent survey of Australian general practitioners (GPs), for example, found 30 % reporting moderate levels of stress, while 10% reported severe levels (Schattner & Coman, 1998).

As a result of huge structural changes occurring in the workplace, there is growing concern about similar stress levels in all workers. Technological advances have moved the emphasis away from physical work to more intellectual demands. The dominance of free market policies has further squeezed the individual worker in the interests of the bottom line. Threats of downsizing have been shown to lead to increased stress and job insecurity, loss of control and cigarette consumption (Ostry, Marion, Green *et al.*, 2000).

The costs of this problem are difficult to quantify, but studies from the UK estimate the annual cost of stress-related absenteeism and staff turnover at 2–3% of GDP. To these costs could be added rising medical expenses, reduced quality and quantity of work, and increased Worker's Compensation costs (McKenna, 2000).

There are little data as yet for Australia, although a household survey of mental health problems conducted in 1998 gives some warnings that work stress may be going largely unrecognised. The survey found a prevalence rate of mental illness in Australians of 1 in 5: a now well-known figure (Department of Health & Aged Care, 1999). Of those identified with a mental illness, less than 60% had consulted a GP in the previous year, and only 30% had been seen two or more times and given a prescription or behaviour therapy. However, for the subset of those with depression and in work, even less (30%) had consulted a doctor. The BEACH Study (Bettering the Evaluation and Care of Health - University of Sydney), looking at GP data over a two year period confirmed this, with only 0.23% of consultations classified as being attributed to work-related issues (Britt, 2001, *pers. comm.*).

At present, those businesses that do address the mental health of their employees mainly rely on external services, like employee assistance programs. These offer treatments outside the workplace, thus maintaining confidentiality, but only to those who self-refer. On average, only 5% of workers utilise such services. The stigma and often disempowering nature of these illnesses is not taken into account in this approach, nor is the perceived risk of discrimination in the workplace.

From both an individual and business perspective, however, there is a growing need for a more holistic approach to work that achieves an appropriate work-life balance. Research confirms there is a link between job satisfaction and quality of life as a whole (Adelman, 1987). And there is renewed evidence of a link between psychological wellbeing and cardiovascular disease (Hemingway & Marmot, 1999).

What exactly is workplace stress?

Research in this area comes from a number of disciplines: medical and paramedical, social and behavioural sciences, as well as management and organisational research. As a result there is complexity, confusion and lack of agreement about concepts, definitions and causes of workplace stress.

In general, there is consensus that stress (a commonly used lay term) occurs when there is an imbalance between two opposing forces: the demands of a work situation and the ability of an individual to make adjustments to them. Much of the research is based on the 'Job-Strain Model' (Karasek, 1979). This recognises that the primary sources of stress lie within two basic characteristics of the job itself: (1) psychological job demands, and (2) job decision latitude. A dynamic interaction occurs between the two, so situations of high workload and low worker control are most likely to lead to stress.

Other job characteristics also appear important and can be summarised as motivating factors (achievement, recognition, responsibility, growth, advancement) and hygiene factors (salary and conditions, working environment, interpersonal relations, status, security).

Research focusing on individual predisposing factors shows an interesting association between work-related problems and Type A personality traits. This presumably has to do with reactions to an inability to attain firmly held ideals and motivations in problematic environments. Other important factors include social support networks, biophysical variables such as age and exercise, as well as genetic considerations.

The effect on the individual of these complex interactions is also variable. A useful progression model, termed the 'general adaption syndrome' (Van Ociul, 1996) describes three different stages:

1. *Alarm reaction*: this is an early response to a perceived threat or challenge, either physical or emotional. The autonomic nervous system is stimulated leading to the well-known stress response.
2. *Resistance stage*: the alarm reaction cannct be maintained long-term, and in this stage people develop a 'survival' strategy to fight against the stressor.

Coping mechanisms may be adequate or inadequate. People tend to prefer short-term relief to long-term solutions and try to escape uncomfortable situations with a quick remedy. Unfortunately, these easy, short-term measures can lead to secondary problems such as long-term reduction in performance. Increased alcohol consumption is a typical example. People need help to identify measures that can lead to long-term benefit.

3. *Exhaustion stage*: when the resources of the individual are overwhelmed by the demands of the stressor. This can lead to both physical symptoms, such as neck and shoulder pain, or emotional disturbance. 'Burnout' is a term used to explain a particular psychological sequelae characterised by emotional exhaustion, depersonalisation and reduced personal fulfilment (Lee & Ashforth, 1990). Other possible outcomes include depression, suicidal ideation and anxiety. Post-traumatic stress disorder is a particular form of anxiety reaction that can occur in this setting.

What does building capability mean and how can it be measured?

It is well recognised that we need to find new approaches to confront a burgeoning 'epidemic' of mental illness, which the WHO predicts will be the second most common cause of ill health by the year 2020 (Clearihan, 1999). Confronted with this growing problem, the medical profession is armed only with treatments of modest effectiveness (DeRubeis, Gelfand, Tang & Simons, 1999). Even when the mainstays of treatment, medication and the 'talking' therapies, are used mental illness remains a chronic, relapsing group of conditions. The time and skills required are also a huge problem for the GP (Smyth, 1995; Mynors-Wallis, Gath, Day & Baker, 2000). Severe obstacles, such as stigma and prejudice, confront a sufferer even before accessing these treatments (Sims, 1993).

One approach is to broaden the focus of treatment beyond individual-focused interventions, and encompass the wider context of the socio-economic, environmental, cultural and political influences at play. Such an approach based in the workplace, aims not only to empower individuals using preventative and early intervention strategies, but to also empower organisations to effectively address the issue and bring about structural change (Brady, 1995).

New fields of research, especially in the area of health inequalities and their social determinants, point to the potential benefits from such an approach. For example, studies of the workplace have shown an individual's sense of control of his/her situation is an important pre-determinant of psychological health (Marmot, Smith, Stansfeld *et al.*, 1991). Similarly, strategies that boost an individual's resilience and problem solving skills can help reduce the long-term impact of mental illness (Smyth, 1995).

From a public health perspective, higher degrees of social cohesion have been shown in international comparison studies to improve health (Wilkinson, 1992). And in the developing world, empowerment has long been established as a powerful tool in addressing ill health (Werner & Sanders, 1997).

The workplace has long been recognised as a promising place to conduct health promotion, especially to access the male population. Evaluation of such programs, however, has failed to bear out this promise (Craig & Hancock, 1996). One explanation for this revolves around criticisms of previously applied study designs. Research into the nature of workplace stress commonly applies traditional cross-sectional designs that are 'at odds with the diverse parties, multiple objectives and partial researcher control that best describes the often turbulent and ever-changing organisational setting' (Israel, 1989). Intervention studies focus solely on the individual rather than the social and environmental factors.

Similarly, a narrow approach is evident in the current analysis of workplace mental health, where the individual is placed at the centre of the 'treatment'. This fails to account for the external contributors such as job security, role recognition, communication with management, career progression, as well as outside family issues.

'Participatory research' is an approach that may overcome many of these concerns. It is a longitudinal design that gives research participants the opportunity to contribute contextual information to every stage of the research cycle. It is a collaborative, reactive approach that leads to co-learning, system development and empowerment (Wallerstein, 1992). The quality of research is enhanced by overcoming mistrust, gaining new insights, building individual capacity and takes into account particular environmental factors.

Evaluation of a 'health development' program such as this is complex, and has been described as the 'next methodological frontier'. One proposed framework takes into account the multiple strategies and timelines employed:

4. outcomes for today: measurable health gains
5. outcomes for tomorrow: improved health promotion
6. outcomes for the day after tomorrow: enhanced institutional, professional and community capacity (Legge, 1999, p118).

Resulting outcomes, both qualitative and qualitative, are thought to improve the quality of results because they allow the cross-checking of discrepancies, provide causal explanations and improve generalisability of results.

Health promotion and the Internet

Health promotion and the Ottawa Charter

In 1986, WHO convened a meeting of health experts from 38 countries in Ottawa, Canada. The task was to address the WHO Target of *Health for All by the year 2000*. The conference built on the previous Declaration on Primary Health Care at Alma Ata and developed key inter-sectoral approaches to achieve its lofty goal. Five broad strategies were highlighted (Box 1) and have come to be recognised as the 'new public health'. These strategies underpin current practice in health promotion.

Box 1

Key strategies - Ottawa Charter for Health Promotion

Develop personal skills
Create supportive environments
Strengthen community action
Build healthy public policy
Re-orient health services
(WHO, 1986)

Although these strategies were developed long before the widespread acceptance of IT, the technology offers a powerful medium to transfer health messages and empower communities to take control of their own health. A discussion follows about opportunities in the five areas, and how they have been harnessed in the development of the OneSmallStep website, a workplace health promotion using web-based technology. The program, which targets workplace health and wellbeing, is currently being trialed in industry settings.

Personal skills

People-focused information can be accessed in a confidential way via the Internet, and offered in an extremely flexible manner to help overcome geographical and time constraints. Help and advice can be received without the awkwardness of divulging personal information to another person. Confidentiality and the user experience are highly important considerations. Rather than emphasising the negative connotations often attributed to stress, we adopt a positive approach that sees stress as an opportunity for change and personal growth

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Individuals can self-assess their health and wellbeing using validated questionnaires. The interactive capabilities of the Internet allow immediate feedback, as well as monitoring of progress by comparison with previous scores. Using an adult learning approach, responses can act as a springboard for individuals to examine the problematic features within their workplace. Content can be tailored to individual users' responses, and can also be presented in varying ways according differing learning styles. Scenarios with multiple-choice responses develop problem-solving skills and allow exploration of cognitive features and learned behaviours.

Links to other sites as well as assistance with seeking further professional help are presented. People can receive more personalised assistance via e-mail and other media if required, although the preventative nature of the resource is emphasised and is not meant as a substitute for professional diagnosis and treatment. Procedures have been developed for when 'at risk' individuals are identified by the site. Increased support is offered to the individual while autonomy is respected.

These advantages are currently being used with success by the 'ReachOut' website (http://www.reachout.asn.au/home.jsp), an initiative of the Inspire Foundation using the social benefits of the Internet to reach Australian young people. Ongoing evaluation of the website, by the Inspire Foundation, has shown considerable youth empowerment and increased utilisation of local health and community services after 24 months.

Supportive environments

Organisational commitment is fostered in the program from an early stage, and collaboration with existing strategies is encouraged. A partnership approach that sees the initiative as a positive opportunity is sought. As the 'knowledge economy' grows, businesses increasingly recognise the importance of taking care of their talent and providing them with a healthy work/life balance. Competitive companies must address the bottom line cost of poor staff retention. Legislative requirements also demand pro-active programs on the part of employers. Concerns of increasing Workers' Compensation claims as a result of the intervention must be addressed.

Whilst maintaining confidentiality, management can monitor stress levels in the workplace much like culture surveys do presently. Problem areas and issues, such as workload and autonomy are identified. Discussion of these psychosocial factors is facilitated in face-to-face sessions and builds the capability of managers to deal with this difficult area. Organisational measures, such as absenteeism, staff retention and occupational health and safety indicators are monitored during the course of implementation as a means of evaluating the program.

Community action

Online forums, moderated by professionals, encourage improved communication and discussion of common issues. Anonymity encourages the exchange of ideas that may otherwise have been kept silent out of fears for job security. The role of moderator is an important one, whereby discussion is fostered and rogue elements minimised. Rather than a 'free for all', discussion 'strands' allow discussion of discrete topics. Expert opinions, and special events create a sense of community and are designed to bring users back to the site.

This community development approach draws on existing human and material resources within the workplace and enhances self-help and social support. It develops flexible systems for strengthening participation and direction of health matters. This can lead to common action for change.

Healthy public policy

Individual responses, from both questionnaires and forums, feed directly into the development of responsive policy, re-enforcing the partnership between individual and employer. Following statistical analysis of the database, we are able to identify factors that predispose to poor mental health in the workplace. Epidemiological features, or job characteristics carrying an increased risk are highlighted.

From this, targeted policy initiatives can help reduce the incidence of these problems in particular workplaces. This may include in one workplace procedural changes to address such issues as flexible working conditions, performance appraisal or career development. Another workplace may highlight the need for childcare or extra safety precautions.

Re-orientation of health services

Health information is taken out of the hands of professionals and placed firmly with individuals. The empowering knowledge is accessed in a strictly anonymous way and improves coverage. The preventive and early intervention strategy, rather than a curative approach, avoids the burden of well-established mental health conditions. It is sensitive to cultural and behavioural differences, as well as contextual factors, and does not impose a generic solution.

The technology opens channels between the health sector and other groups representing community, government and other stakeholders. This enables a broad approach to the pursuit of health.

Conclusion

Workplace stress is an important health issue that is under-recognised and poorly treated within our society. Its impact on individuals, their organisations and our community is immense. Equal participation in employment and the economic opportunities that follow are important prerequisites for a healthy and happy society.

There are, however, many factors currently obstructing us from enjoying the full benefits of work. The Internet presents a powerful opportunity to engage and empower the many stakeholders involved, and to help us all to discover greater satisfaction at work.

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...I SUDDENLY CAME OVER ALL BOLSHIE...

18 *beyondblue* – The National Depression Initiative: preventing depression in the workplace

Karen Field, Nicole Highet and Elly Robinson

Introduction

Depression is recognised internationally as a leading cause of medical illness and disability, which affects over 800,000 people every year in Australia. It represents a major public health challenge to the western world in terms of the huge personal, family and financial costs involved. Those with severe affective disorders are at high risk of relapse, long-term physical illness, social dysfunction, accidental death and suicide (see Box 1, below)

Box 1
Focus groups
A series of focus group discussions with consumers identified the inability or unwillingness for workplaces to view depression as an illness, in turn resulting in overt and covert discrimination. Participants indicated that informing their organisation of their depressive illness resulted in an inability to get work, or being undermined and overlooked for promotion. Other consumers reported losing their jobs as a direct consequence of their depressive illness (McNair et al., 2002).

What is *beyondblue*?

beyondblue provides a national focus for depression-related activities and heads a population-based approach for reducing depression. It endeavours to have a major impact at family, social and local community levels, and creates new mechanisms (for example, national consortia) to bring together the wide range of knowledge and expertise already existing in Australia. *beyondblue* mobilises partnerships and promotes collaboration involving the media, business, health services, community and consumer organisations, regional authorities and governments.

beyondblue has five key goals, and the programs currently supported by *beyondblue* typically represent one or more of the following domains:

1. Community awareness and de-stigmatisation.
2. Prevention and early intervention.

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3. Consumer and carer issues.
4. Primary care.
5. Strategic research.

The depression in the workplace program essentially is seen to represent three of the above corporate goals, namely:

i) community awareness, de-stigmatisation, and literacy
ii) preventive programs and research
iii) training and workforce support.

beyondblue has adopted a public health approach to reducing the prevalence of depression in Australia. This approach recognises both the complexity and multi-factorial nature of the causes of mental illnesses such as depression, and argues the need for a spectrum of interventions including mental health promotion, prevention, early intervention, treatment and continuing care (Mrazek & Haggerty, 1994).

Given the current unmet need and high cost of treating depression, population-based interventions that focus on the up-stream determinants of mental health and wellbeing are required in order to prevent both the onset and level of disability associated with depression. Interventions have often utilised specific settings of social organisation such as whole communities, schools or targeted population groups, and are showing promising results (Berkham & Kawachi, 2000).

Why the workplace?

The workplace offers an additional, similar setting in which to apply a multimodal population health approach that encompasses the different aspects and experience of mental health and illness. Specifically, the approach would target the psychosocial determinants of mental health in the Australian community by aiming to modify workplace-based risk and protective factors in a positive direction (Burns & Hickie, 2002).

beyondblue considers the workplace is an important social organisation setting for a population mental health approach for a number of reasons:

- A large Australian population study in 1999 indicated that adult persons with depression had, on average, 2.7 days out of their work role per month, thus accounting for some 2.1 million person-days out of role per month overall in Australia (Henderson, Andrews and Hall, 2000). Depression, therefore, can be seen as a considerable disruption to the workplace for sufferers and their colleagues.

- Many Australians spend significant periods of their adult life in workplaces. Any interventions that target health risks and behaviours in the workplace will have positive flow-on effects into other key social settings, as most workers are also active members of families and communities.
- For adults, the workplace provides many opportunities for positive mental health promotion, such as the development of significant social relationships, personal development/achievement and financial security. In addition, the workplace as an intervention setting provides opportunities for enhancing resilience through a focus on protective factors associated with positive mental health.
- The relationship between mental health/wellbeing and working conditions is becoming increasingly important. A number of studies have linked mental ill health including depression, to work conditions such as work that encompasses high psychological demands and low decision latitude (Berkham & Kawachi, 2000). In addition, the National Mental Health Action Plan for the Promotion, Prevention and Early Intervention of Mental Health (Commonwealth Department of Health and Aged Care, 2000a) lists a number of risk and protective factors directly linked to the workplace, such as job insecurity, unsatisfactory workplace relationships and economic security.
- Like other aspects of society, the workplace is currently undergoing major changes in response to social forces. These include globalisation, increased financial competition placing greater demands on productivity, changing communication strategies that alter how and where we do business, and the changing nature of employment with increasing risks of unemployment, short-term or unstable employment and varying nature of work tasks. The nature of work itself is changing from being less physically but more psychologically demanding. Such changes have the capacity to influence the health of workers in the future and through transference, may influence health in other social spheres of their lives, such as the family and community (Berkham & Kawachi, 2000).
- Given the increasing financial burden of work-related mental health insurance claims (Workcover) and losses in productivity, employers are increasingly motivated to examine and address mental health and wellbeing issues in the workplace.
- Many consumers and carers talk of issues to do with continuing participation in the workplace as important, not only in terms of the recovery process but also in terms of support and understanding for

those experiencing the illness or caring for someone with a mental illness. Issues of discrimination continue to have an impact on both consumers and carers (see Box 2).

Box 2

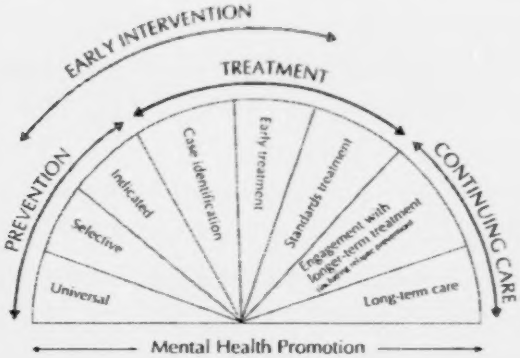
Comfort scale

Suppose someone in your workplace was experiencing depression. Using a scale from 0 to 5 where 0 is very uncomfortable and 5 is very comfortable, how comfortable would you be to...

Approach them and see what's wrong?
Go and talk to someone, for example a supervisor?
Take them away from the office for a coffee?
Talk to someone like a human resource manager?
Take them for a walk outside the office?
Stay in contact after work hours?
Encourage them to take some time off work?

A workplace model for preventing depression

The National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000 has adapted the spectrum of interventions for mental health problems and mental disorders first put forward by the US Institute of Medicine (Mrazek & Haggerty, 1994). The revised spectrum is reprinted below.


EARLY INTERVENTION
TREATMENT
PREVENTION
CONTINUING CARE
Universal
Selective
Indicated
Case identification
Early treatment
Standards treatment
Engagement with longer-term treatment
Long-term care
Mental Health Promotion

Source: adapted from Mrazek & Haggerty (1994) in CDH&AC (2000a, p7)

Figure 18.1 Revised spectrum of interventions for mental health problems

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The National Action Plan (CDH&AC, 2000a) acknowledges that responses to mental health issues require a broad range of activities across the spectrum. The plan itself focuses on national efforts to address mental health issues that encompass mental health promotion and prevention, including an increasing emphasis on early intervention. In addition, the plan states that:

> *Although the goals of promotion, prevention and early intervention differ, there is often considerable overlap. An intervention aimed at increasing wellbeing in a community (promotion) for instance, may also have the effect of decreasing the incidence of mental health problems (prevention). Intervening early for mental health problems (early intervention) may prevent the development of diagnosable disorder (prevention) (CDH&AC, 2000a, p7).*

beyondblue believes the ultimate, most effective approach to addressing the prevalence of depression within a specific setting (such as a community, school or workplace) encompasses the full spectrum of interventions outlined above. Such a holistic approach will:

- optimise mental health and wellbeing,
- prevent onset of the illness,
- screen for and identify those at risk and in need of specific interventions or those with symptoms of the illness who require early intervention to avoid the full disorder,
- help to provide those with the disorder with the required evidence based treatment/s,
- ensure ongoing holistic care and monitoring of the illness, and
- help to provide interventions to assist or to maintain recovery.

Initial efforts should focus on creating an environment where the benefits of mental health promotion and an awareness of mental illness are prominent. This includes clarifying the motivation/s behind the settings, and its constituents' adoption of mental health promotion, prevention and treatment practices. The implementation of such a model requires commitment and understanding at all levels of the workplace; in other words, to see it as 'their business'. This includes the workplace being prepared to examine its:

- *Structures and function:* including the way in which work is organised, operating policies and practices, organisation structures and lines of authority/delegation and decision-making.
- *Current staff management and development practices:* including staff health and welfare policies and practices. There would need to be an examination of current data in the organisation with regard to mental health and illness issues and how they currently impact on the organisation or are addressed within the organisation.

A multi-modal 'whole of workplace' approach would focus on all areas depicted in the spectrum, and it is suggested the following aspects would be included:

1. Mental health literacy.
2. Mental health promotion.
3. Prevention (universal, selective and indicative).
4. Treatment.
5. Continuing care.

Mental health promotion

Mental health promotion interventions focus on maximising the mental health and wellbeing for populations and individuals, as opposed to a focus on illness (CD&HAC, 2000b). One way of viewing mental health promotion is as a 'subset' of the approach laid down by the Ottawa Charter (WHO, 1986), a landmark health promotion document. The major feature of the Charter is its focus on five action areas for public health:

- Building healthy public policies
- Creating supportive environments
- Strengthening community action
- Developing personal skills
- Reorienting health services.

These health promotion action areas reflect the call for a holistic approach to health by encompassing environmental, social and individual factors. An example of such an approach has been adopted by the Health Promoting Schools strategy (see Box 3 at end of chapter). Strategies to promote mental health in the workplace may apply these five action areas to the broad issues surrounding mental health, similar to the Health Promoting Schools approach. For example:

- Building healthy public policy - by developing coherent workplace policies for mental health that recognise the importance of addressing biological, ecological and social dimensions
- Creating supportive environments - by utilising the workplace setting to encourage reciprocal support and connectedness between all workers in regard to mental health issues
- Strengthening community action - by drawing on the wider community in which the business exists, including family and the local environment, and involving that community in aspects of decision-making and plans pertaining to workplace mental health initiatives

- Developing personal skills - by providing information and education on mental health issues, encouraging help-seeking behaviour and opportunities to enhance coping strategies within and beyond the workplace
- Reorienting health services - by recognising aspects of the workplace that can play a proactive, less traditionally defined role in mental health promotion, such as occupational health and safety personnel or work-based social clubs.

Opportunities to promote mental health issues in the workplace are numerous and often straightforward. For example, practical approaches may be as specific as placing information regarding stress reduction in the staff room, or as broad as incorporating mental health aspects into a range of critical workplace policies.

Prevention

Preventative interventions are aimed at preventing the onset and development of mental health disorders. According to the mental health intervention spectrum, outlined above, there are three levels of prevention. Interventions at the population or universal level aim to modify risk and protective factors and other determinants that have a known association with a disorder, such as depression, for an entire population. Thus, the intervention is targeted at the whole population, regardless of whether individuals have symptoms of, or existing, mental health issues.

Other prevention interventions include activities that seek to address those individuals who either have a known or higher risk for developing the disorder (selective) and others who currently display early signs or symptoms of the disorder (indicated). Early intervention initiatives may blur the boundaries between indicated interventions and early treatment of mental illness, as these initiatives specifically target people with early signs and symptoms of mental illness as well as those who may be developing or have experienced a first episode. Examples of preventative interventions that may be conducted in the workplace include:

- the provision of information to all staff on stress management (universal prevention)
- conducting a workplace audit of staff to profile known risk and protective factors related to mental health (such as those outlined in the National Action Plan). This would form the basis for identifying and implementing programs based on identified needs. Such programs

could include specific support and workplace counselling to those who are experiencing family breakdown (selective prevention)
- policies and procedures that enable those experiencing workplace stress to have structured, supported and paid 'time out' from their employment (indicated prevention)
- policies that deal effectively with the identification and management of staff who are experiencing burnout, such as a period of counselling for those who have been involved in, and are responding negatively to, a traumatic event as part of their work (early intervention).

Treatment

Treatment includes early interventions that seek to identify first episodes (such as screening programs) and the known standard treatments for disorders.

While it is understood the vast majority of workplaces cannot play a role in the provision of treatment, there is a considerable role in the way the workplace approaches, encourages and provides a pathway to treatment for staff who are experiencing mental illness. Such support could include going with and supporting a staff member to attend a treatment provider, or identifying and establishing protocols with key mental health providers of effective treatments for staff to utilise. Given the current unmet need for treatment and the lack of a provision of effective treatments, the workplace could provide a crucial role in terms of securing this pathway whilst maintaining consumer confidentiality and privacy.

A broad understanding of the process and nature of treatment by senior staff may also facilitate a more supportive environment for other staff dealing with mental illness. The workplace has a critical role to play in terms of recovery that encompasses a managed and facilitated return to work. It is important to understand that recovery is a process not an event and thus the return-to-work planning needs to be individualised and responsive.

Additionally, the issue of discrimination within the workplace continues to impact negatively on people with the illness and their recovery, in particular a lack of understanding and/or willingness to view depression as a legitimate illness (McNair, Highet, Hickie & Davenport, 2002). Discrimination is a pervasive issue in workplaces that requires a positive and proactive response.

Continuing care

Continuing care includes interventions that are aimed at individuals who continue to experience or have recurrences of disorders. Often continuing care will be aimed at preventing relapse or recurrence of illness, rather than responding to illness. In this sense, it should be seen as a proactive undertaking by staff, which requires support and consideration.

Issues associated with continuing care are similar to those of treatment, with an understanding and supportive workplace environment providing the best possible opportunity for full recovery and productivity from affected workers.

Evaluation

The evaluation of such a program is also of critical importance. In particular, it is imperative that the evaluation framework reflects the wholistic model presented above, and targets the various stages and levels of intervention.

The proposed model evaluates process outcome evaluation methods across the components/stages. For example, at the first level; mental health literacy, this is likely to involve of implementation of the developed *beyondblue* Depression Literacy Survey to measure depression literacy within the target organisation (which is undergoing the literacy training) and a matched control organisation (which does not receive the literacy training). This should include two assessment points; one before the commencement of the training, and the other following the training. In addition, the existence of community data derived from *beyondblue*s' wider community surveys, enables comparison of data also with the general community (Figure 18.2).

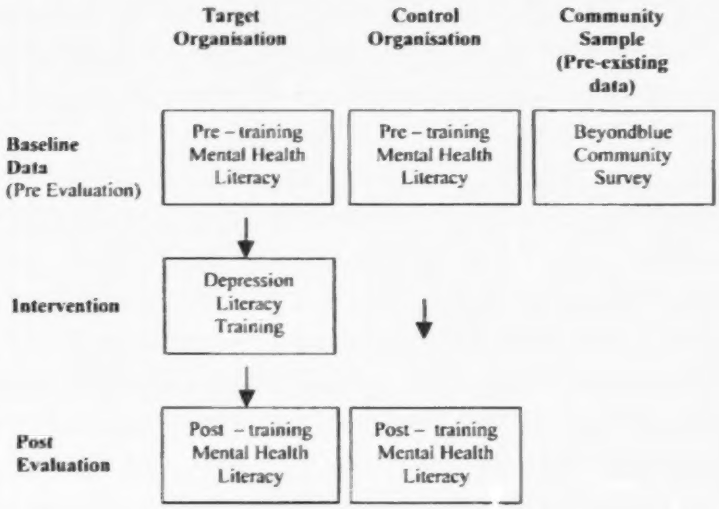
Target Organisation
Control Organisation
Community Sample (Pre-existing data)
Baseline Data (Pre Evaluation)
Pre – training Mental Health Literacy
Pre – training Mental Health Literacy
Beyondblue Community Survey
Intervention
Depression Literacy Training
Post Evaluation
Post – training Mental Health Literacy
Post – training Mental Health Literacy

Figure 18.2 Model for evaluating impact of mental health literacy

In addition to these outcome measures (depression literacy) there will also be process evaluation. This is likely to consist of an alternative depression literacy method, namely the depression vignette developed by Jorm, Korten, Jacomb, Christensen, Rogers and Pollitt (1997) that will be conducted immediately prior to, and on completion of, the training itself. Not only will this enable depression awareness and knowledge about depression and treatments derived from the training to be assessed, but it can be extended to include awareness of services within and outside the workplace setting that may be appropriate for the treatment of depression.

Similarly, such an evaluation framework will also be applied across the other stages (2-5) described above. For example, evaluation of data pertaining to days out of role, and length of time taken to seek treatment will also be obtained, and compared across time and settings.

Conclusion

The depression in the workplace program utilises a wholistic model, targeting a number of interventions (and evaluation procedures) across the whole of the workplace spectrum. Ultimately, such an approach will serve to not only promote change at each of these stages, but importantly, will serve to ensure these changes are sustainable over time.

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Box 3

Health Promoting Schools

The concept of the health promoting school has been developed considerably over the past decade, as part of the new public health movement emanating from the adoption of the Ottawa Charter (WHO, 1986). It is based on the idea that school is a place where children and young people spend a large number of their formative years and accordingly, is an appropriate setting to promote healthy practices and health enhancing skills and knowledge to large numbers of students. Health Promoting Schools aim to develop a healthy school community by focusing on the democratic process of achieving 'health for all' (as proposed in the Ottawa Charter). This overall goal of 'health for all' clearly involves an identification of social justice issues such as gender, cultural and socio-economic factors and how they impact on the school community. The five action areas of the Ottawa Charter have influenced the development of the health promoting school concept in the following ways (Colquhoun, Goltz & Sheehan, 2002):

- Health promoting policy - by developing coherent curricula in education for health, which bring biological, ecological and social dimensions to a process of environmental health
- Creating supportive environments - by utilising the setting of the school to encourage reciprocal support between students, teachers and parents
- Strengthening community action - by drawing on existing human and material resources in the community surrounding the school, and involving that community in practical aspects of the decisions, plans and action pertaining to the project
- Developing personal skills - by providing information, education for health and opportunities to enhance life skills within the school community setting
- Reorienting health services - by involving the school health service in project activities aimed at the promotion of health, by utilising the skills of school health professionals on a broader basis than traditionally defined roles.

The health promoting school is a good example of a shift away from traditional practice, such as school health education based on classroom or formal curriculum activities, to a more holistic approach. Traditional school health education tended to be individualistic and focused on changing individual behaviour. Health promoting schools, in contrast, incorporate the physical, social, affective and environmental aspects of health promotion by involving the individual, school and wider community. Clearly, compounding trends in education, such as increased demands on teachers and schools, fluctuating retention rates, corporate managerialism and limited opportunities for professional development, have meant that any analysis and development of the health promoting school in Australia is located in a complex and changing context. Large-scale changes such as the implementation of a Health Promoting School plan, or in fact any health promotion programs, are difficult to incorporate if the workforce is stressed and burnt out. These are serious considerations that may need to be addressed when implementing ongoing programs such as these.

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19 More than a hairdresser

Trevor Waring

More than a hairdresser

Serendipitously, a busy hairdresser, on discovering that her client was a psychologist, commented that she felt she was one also – 'in a kind of way' – in that her clients frequently engaged in long and detailed discourses about the everyday dramas encountered as they went about their lives. Most often the stories were matters of little consequence; however, it was also at least a daily occurrence that clients disclosed issues of considerable importance to them and they frequently sought counsel from the salon worker whom they'd grown to know and trust over the years.

Indeed it could be asserted that hairdressing is the only profession outside the acknowledged health disciplines, save for that often-claimed 'oldest profession', where clients invite the service provider into their personal space for extended periods of time. Often as a consequence, the client, experiencing the intimacy of personal contact, links this sense of safety to other intimate areas of their life, feeling free to disclose aspects of their day-to-day existence. This phenomenon raises questions of the evolutionary link with the role grooming plays in social ordering among other primates.

On further questioning, the hairdresser acknowledged that on most occasions she was left floundering for a response to the regular question, ' ...... so what would you do in my situation?' Other situations causing her considerable concern included gossipers, distressed clients, depressed clients, relationship problems etc., bringing a comment that she wished 'she had been taught some of these things at tech'.

The Hunter Institute of Mental Health is a self-supporting unit of the Hunter Area Health Service and aims to provide mental health professional development services to Hunter-based mental health professionals, pursue mental health promotion activities and undertake mental health research. One of its main activities in the late 1990s and early 2000s was, along with many others around Australia, to undertake a wide range of projects aimed at arresting the alarming suicide rates causing great concern among all sections of society.

One such project the Institute had been working on under contract to the Commonwealth Government was the development of educational packages for undergraduate students in nursing education and medicine. The objective was to alert these young professionals in training to those at greatest risk of suicide with the obvious intention of providing them with the tools to usefully intervene as they pursued their careers down the years. Unpublished surveys of mental health professionals undertaken in preparation for this work had shown that these disciplines were most likely to come in contact with at risk groups, particularly young people, and be best placed to helpfully intervene.

It did however dawn on Institute staff following the reported conversation with the mentioned hairdresser, that persons involved in the hairdressing industry could well be another significant group of 'gatekeepers' coming in contact with large numbers of the public and the recipients of confidences requiring careful handling for which they had next to no training. Anecdotal evidence suggested that many people chatted with their hairdresser about personal aspects of their lives and not infrequently sought advice on matters with which they were currently grappling.

While an obvious response was to encourage the hairdressing training authorities to develop a curriculum resource addressing this perceived need, the evidence for such encouragement was only anecdotal. The sense of subject importance was linked to the Institute's values and not necessarily shared by those with enough to do in training hairdressers without the added burden of training 'barefoot therapists'. None the less, it was a case of many becoming 'accidental counsellors' and better they do it well than not.

Later media reports of hairdressers leaving the profession because of emotional fatigue in bearing the brunt of many a client's need to unburden their woes spurred the Institute's interest to try and gather some data. The perceived needs of hairdressing personnel in the area of dealing with troubled clients and other interpersonal client communication issues were prime targets. A senior social work student was recruited in early 1999 to undertake a pilot study aimed at determining the local hairdressing industry response to an assumed need for training in communication skills and dealing with the disclosed situational problems of clients' personal lives. An international literature search on the topic was also conducted producing nothing of value or relevance to the area under interest.

A database of all hairdressing salons in the inner New South Wales city of Newcastle and immediate surrounding suburbs was created. From this data base a random list was generated aimed at procuring a sample of 25 salons that would be asked to participate in a short face-to-face interview. Around sixty salons were contacted by phone with a pre-arranged message seeking interest in the face-to-face interview before the n=25 target was reached. Of the salons declining involvement, the main reasons given were time limitations, limited staff numbers or indeed the suggestion that they had 'all the communication skills they needed'.

The face-to-face interview covered a number of relevant questions including:

- Have you or any of your staff ever been told something by a client that has left you feeling uncomfortable about how to respond?
- How was this situation dealt with?
- Have any clients asked you for advice?
- How did you respond to this?
- If you thought a client needed professional counselling, would you know how to raise it with them?
- Would you know where to send them?

Those interviewed at the sample salons were also asked about their training needs in the area of communication and dealing with troubled clients and whether they had ever had any such training.

The majority of respondents (80%) had been told things by clients that had left them feeling uncomfortable about how to respond. Of these 75% said the issues surrounded a serious health problem or impending death. A greater number (81%) said they felt uncomfortable when issues concerning personal relationship complications were disclosed. Interestingly, the most common, and regarded as the most difficult to deal with, were issues related to the behaviour of the client's children such as drug use or matters of appropriate discipline.

About a half of the sample said they just let their client talk while another third said they didn't know what to say. Almost two thirds (65%) reported being regularly asked to give advice mainly on relationship issues and other matters concerning their family. One third said they were cautious in giving any advice but would do so if pressed. Another third said they would give advice if they 'knew the answer' and the remaining group had no hesitation in advising clients.

Sixty percent of hairdressers surveyed said they would raise a client's need of professional help if they knew them well enough and do it in a friendly manner, while the remaining 40% said they would not know how to raise such an issue even if they did know the client well. Despite the majority being prepared to raise a client's need of help, most didn't know where they could refer them. One thing was certain from those interviewed and that was that they would value training. However, finding time away from the salon in a very competitive and busy market was a significant barrier.

It was in response to this latter problem of 'time away from the salon' that the Institute decided to produce a training video for the hairdressing industry to enable individual staff members of even the smallest salons to find time to view the video and perhaps benefit from its emphasis. It also became known that some of the larger salons conducted in-house training evenings and so to accompany the video a set of study notes would be designed to assist management to conduct conversation sessions following a screening of the video. The video was to be titled 'More than a hairdresser'.

To produce a good quality training video, requires professional writers, actors and producers and unfortunately these can be very expensive. It was imperative that the product be professionally produced and marketed to recoup costs. A degree of entrepreneurial risk was necessary; however, the Institute believed strongly in the project and its potential to be helpful and a decision was taken to push ahead.

The resultant product consisted of six scenarios research had shown to be typical of those bringing concern to hairdressing personnel:

- A client trying to engage in gossip with her hairdresser.
- A client asking for advice about a family feud.
- A client distressed about her marriage break-up.
- A client with low self-esteem.
- A client trying to elicit confidential information from her hairdresser.
- A client coming to have her hair done to attend her husband's funeral.

Each scenario was presented in the following manner. The narrator (a clinical psychologist) introduces the scene and provides some background to the interactions that follow. The scenario is presented featuring a hairdresser who is considered to be interacting poorly or inappropriately with the client. At the conclusion of the scene, viewers are directed to pause the video and discuss a set of questions that appear on screen. When the video resumes, the clinical psychologist offers some suggestions about how the hairdresser could have better managed his or her interaction with the client.

The same scenario is then repeated with the hairdresser considered to be acting more appropriately for the situation. The study notes produced to accompany the video provide extra information for the presenter to encourage discussion. However, presenters are encouraged to try and obtain the assistance of a local mental health worker where a group presentation is anticipated.

One example from the video may suffice in illustrating the kind of content and level at which the resource is aimed. One of the scenarios presents 'Christine', a thirty-something year-old salon worker who is not backward in coming forward with 'advice' for her clients regardless of the topic or situation, and indeed can come across quite 'pushy' at times. 'Liz', a regular client in her mid forties is portrayed as seeking advice on a problem she is having with her sister, also a customer of the salon. The scene opens with Liz asking for advice on just how she should handle her sister and Christine obliges!

The questions appearing on screen after the pause challenge the viewer to question whether the hairdresser is acting professionally and why she should or shouldn't give the customer the benefit of her opinion. Could the situation 'blow up' for the hairdresser and what might be some more helpful ways of responding than simply a response that begins with 'If I were you...' The narrator and the notes draw attention to the dangers in being enticed into giving direct advice and offers examples of the often subtly put questions that can seduce, for example, 'What do you think?'; 'What would you do in my position?'; 'I'm right aren't I?'; 'You'd have to agree she's being a cow?' and 'Do you think I'm doing the right thing?' etc.

Viewers are encouraged to avoid giving direct advice and are offered some pointers in dealing with requests. These include:

- Try not to offer direct advice to your clients. Try to avoid saying things like 'If I were you…' or 'You'd be mad not to…'
- If a client speaks about a problem, acknowledge their dilemma with words like 'I can see the problem' or 'That sounds like a decision not to rush in to.'
- If a client asks you directly for your opinion, for example 'What would you do?', use distraction techniques to avoid having to voice your own opinion. Use phrases like 'I really don't know' or 'I'm really not the best person to ask…'
- Finally, you can sometimes elaborate on a response by referring the client to another source of information. For example, 'That sounds like something you need to talk about with a real estate agent/doctor/psychologist/priest/parent' etc.

The video was launched in early 2000 and quickly found acceptance, particularly among the Technical and Further Education centres throughout

Australia where hairdressing was taught. Many individual salons also purchased copies and international interest was soon aroused. The video has now been sold in New Zealand, Canada and the United Kingdom as well as every state in Australia.

The media also became interested in what they viewed as a novel pursuit. The project enjoyed airing on national current affairs television, numerous state and national newspapers and magazines and scores of radio stations. Internationally, project instigators were interviewed on world broadcast radio bands such as the BBC World Service as well as articles appearing in international newspapers and magazines.

Of some interest is the recent discovery that the video is also being used for some junior nurse training as the scenarios are similar to situations confronting nurses in their dealings with patients on a day-to-day basis, that is distressed patients, low self-esteem, grieving patients and relatives, avoiding gossip etc.

While the video has not been formally evaluated, anecdotal evidence and customer feedback has been universally positive. Indeed, requests have been received from customers, particularly those involved in the training of hairdressing professionals, for further more detailed and specific training videos. Topics such as 'dealing with the difficult client', 'dealing with the angry client', 'dealing with inter-staff conflict' and communicating with the elderly are examples of the demand for skills beyond professional hairdressing education. The need is not new. What is new is the response to the need and the recognition that when a person tends the personal grooming requirements of another human being, something perhaps very primitive is tapped and the service provider becomes more than a hairdresser.

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20 Mentally healthy workplaces – a living toolkit

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Organisational and individual areas of stress and distress are increasingly a feature of the work life of many individuals, and workplaces. Market research undertaken in workplaces and communities around New Zealand highlighted a range of organisational and individual issues contributing to mentally unhealthy workplaces, including discrimination, intolerance and misunderstanding of mental illness, abusive behaviour and bullying, poor conflict skills, drug and alcohol issues, life relationship problems and unhealthy work-life balance. A key strategy of the Mental Health Foundation of New Zealand for workplaces is the development of a 'toolkit' of resources to build successful and robust workplaces and communities through promoting all-round wellbeing - for employees, employers and the community within which workplaces operate. This paper features some of the understandings influencing development of the toolkit to date.

Introduction

The workplace is a focus of international attention as an environment affecting mental health. For example, the World Federation for Mental Health designated the workplace as the focus of Mental Health Awareness Week in both 2000 and 2001 and the World Health Organisation warns of epidemics of workplace stress and depression (WHO, 2001). What is required to make mental health promotion effective in the workplace? The Mental Health Foundation of NZ, a mental health promotion charitable trust, is currently extending its information and resources available to workplaces.

Initial market research was undertaken by the Mental Health Foundation of New Zealand as part of the process of developing a toolkit of resources for mentally healthy workplaces. A brainstorming group, phone interviews and face-to-face interviews were conducted with human resources managers, line managers and employees from more than 30 workplaces in the Auckland region across a range of industries. The information that follows here is based on findings from this unpublished commercial study. Readers may contact the authors for further information about the study, and access the web site provided.

Mentally unhealthy workplaces

Many of those interviewed in the market research could cite examples from their workplaces of negative impacts of mentally unhealthy practices or experiences. They had limited awareness of preventative or early intervention strategies at an organisational or individual level and there was a strong desire for practical, basic information as the following examples show.

> **How do we talk to each other (from a factory floor with a mostly male workforce)?** At our place, it's common for guys to get a bit abusive when a machine f***s up or they're having an argument. They throw things at a machine, slam doors, kick rubbish bins, let off steam at passers-by, go for a smoke and that sort of thing – just venting it.

The manager went on to describe situations where this 'venting' became too disruptive or destructive within the team. He wanted staff trained to talk to each other and supervisors trained to manage or prevent conflict better. He was also concerned about workers' alcohol and drug use.

> **Relationship problems**
> Managers in a number of industries said it was common for both managers and sales staff to have marital problems and break-ups because of their work patterns. One manager wanted marital and relationship skills to be taught in the workplace – he reckoned it would save him tens of thousands of dollars each time a sales rep went through a relationship crisis in terms of lost productivity and sometimes, staff turnover.

> **What's going on (car rental company)?**
> An employee's behaviour got increasingly inappropriate, including asking others why they were talking about her, shouting at senior management and threatening to bring a weapon to work. Disciplinary procedures were considered but the HR and management team felt it wasn't the best way to deal with the situation. They rang around local health services trying to get help on what to do, not even really sure what or who to ask. In the end, the family organised the person's mental health care and she disappeared from work, with whispers going around the workplace that she had ended up in the 'loony bin'. (In fact, she had a diagnosis of a depressive episode with psychotic features, from which she recovered, but did not return to that workplace.)

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Mentally healthy workplaces

In the market research, positive mental health was related to 'productivity' and 'peak performance' in individuals, teams and organisations. Business people we talked to also interpreted good mental health at work in terms of:

- accounting for people's feelings
- communicating effectively
- having satisfying workplace relationships
- dealing with difficulties quickly and effectively.

Being 'mentally healthy' was closely aligned with competence:

- in work tasks – being good at the specific tasks of the job
- in communicating and relating – ability to express one's feelings and understand other's, and maintain good relationships
- with boundaries – able to set personal boundaries ('not getting personal')
- with balance – balances between work and home life
- in taking on informal mentoring, mediating and counselling roles
- in taking responsibility and initiative on behalf of the company - for others and the tasks of their own job
- in getting the company to provide a good working environment (to minimise environmental stresses)
- in getting the company to provide good technology to do the job (to minimise task-related stresses).

A 'mentally healthy' team and workplace culture emphasised:

- trust
- friendship/ camaraderie
- practical support with problems in the workplace and home
- shared values and goals
- shared understanding (including noticing signs and symptoms of unhappiness)
- equality (between people)
- effective teamwork/ leadership (between roles)
- rapid resolution of difficulties and conflicts using resources within organisation
- meeting team and organisational productivity targets.

Workplaces are strongly motivated to achieve these qualities and practices where they promise individual and organisational success. They see gains in enjoyment, safety, motivation, staff retention, productivity as well as limits to accidents and stress. It is also clear that an indirect effect is to normalise mental health and de-stigmatise mental illness, though this may not have been an immediate goal.

Strategy issues for workplace mental health promotion

Findings from our market research showed that at times, there appeared to be differing understandings of 'mental health' between managers and staff, as well as between managers and mental health promoters. For example, some staff felt mental health policies were designed but not implemented to their own satisfaction. Some managers assumed 'mentally healthy workplaces' meant employing people with mental illnesses and feared this. And generally, some felt that mental health promoters started by assuming workplaces were mentally unhealthy as a rule.

In terms of creating supportive environments and strengthening community action, key elements of the Ottawa Charter for health promotion, the workplace is clearly an ideal site for encouraging developments to improve mental health (WHO, 1986). However, the language and strategies of mental health promotion in the workplace setting must have a close fit with the existing language and culture of business. They also need to account for differing needs between managers and staff, different roles and different industries. Businesses have a powerful orientation towards 'peak performance' of individuals and organisations. The clear message from our research was that businesses want practical, helpful tools to improve productivity and can see that a mentally healthy organisation is also potentially a more enjoyable and profitable one.

Mental health promoters have the expertise to help organisations develop quality in their workplace conditions and structures. A critical workplace mental health tool is ongoing feedback from both managers and staff: Are both productivity and good mental health practices actually happening? Are both managers and mental health promoters accountable for initiatives in this area?

Putting it into practice

As a result of its market research, the Mental Health Foundation is developing a toolkit of easy-to-read, practical information with input from a range of community stakeholders. Piloting the toolkit will begin through the latter half of 2002.

This work is also being developed in the context of legislative changes to the New Zealand Health and Safety in Employment Act (originally introduced in 1992) to more clearly specify 'work-related stress' and 'mental harm' as workplace hazards (New Zealand Parliament, 1993). Media response has already highlighted a climate of fear and misunderstanding about managing workplace stress, which the broader concept of 'mentally healthy workplaces' should go some way to counter.

Ongoing development of the toolkit can be found on the Mental Health Foundation of NZ website at www.mentalhealth.org.nz

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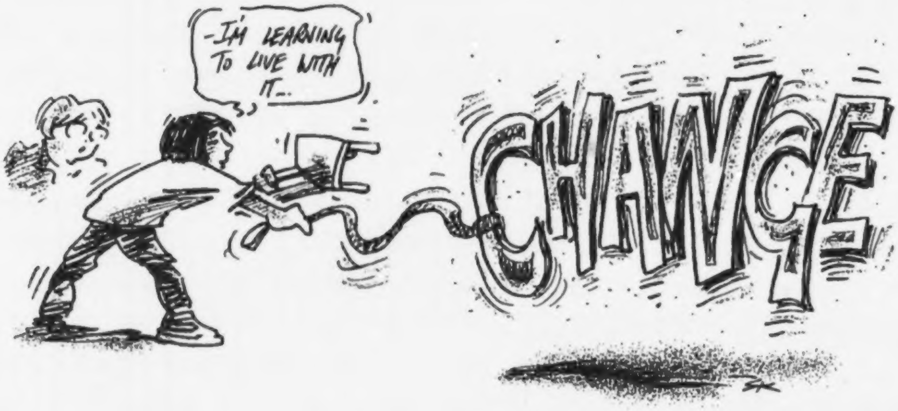
-I'M LEARNING TO LIVE WITH IT...
CHANGE

21 Promoting mental health in nurses through clinical supervision

Daniel Nicholls and Bec Mitchell-Dawson

This paper provides an innovative response to VicHealth's *Mental Health Promotion Plan* for 1999–2002 regarding the mental health needs of nurses working in specialist mental health services in Victoria, expressly in relation to the three determinants of mental health identified in the Plan: increasing connectedness and belonging, reducing discrimination, and maximising economic participation. The response is premised on the observation that nurses working in specialist mental health services require ongoing support in order to deal with continued exposure to the psychological and physical crises and circumstances of consumers of health services, and to ensure these nurses remain a skilled, competent and satisfied workforce.

We argue clinical supervision is a crucial element for nurses who seek to deliver best practice in that they develop an understanding of their effects on others and others' effects on them. It is also crucial for consumers in that nurses constantly evaluate their own role in interactions with them. The desired result of clinical supervision then, is that through careful reflection, nurses gain a better understanding of their interactive skills. Arguably, this demonstration of professional responsibility impacts positively on their own mental health. We introduce and elaborate a form of clinical supervision termed 'mutually supporting, descriptive supervision' and discuss the philosophical bases of this approach.

Introduction

This paper is written largely in the context of nurses who work in the specialist mental health field in Victoria. This does not ignore the fact all nurses are now considered to require a broad understanding of mental health issues – a major reason for the introduction of comprehensive undergraduate nursing programs, an acknowledgement all consumers of health services have mental health needs. Comprehensive nursing education programs look to an outcome of a first level practitioner who, theoretically, can work in any field of nursing. That introduction has accompanied, in many respects, a transformation of specialist mental health services and societal attitudes. The former 'psychiatric nurse' thus experienced what we might loosely term a 'crisis of identity' in social terms. Even the name is problematic: a mental health nurse can now be something other than a psychiatric nurse.

In this paper, we choose the term 'specialist mental health nurse' to describe a certain kind of nurse, in an acknowledgement there is still a specialty involved. It is noted however, that the terms 'mental health nurse' and 'psychiatric nurse' are still in use to describe someone 'who has achieved the status of a specialist nurse by specific education in the mental health field, by separate registration, or by a bona fide credentialling process' (Clinton & Hazelton, 2000). Notwithstanding the subtleties of the terminology, this paper focuses on the mental health needs of those nurses working in specialist mental health settings.

In writing this paper, we draw on our experience in clinical practice, management and education. We attempt to elucidate (and overcome) the seeming paradox that clinical supervision, though by no means a form of therapy in its operative state, can indeed promote mental health in nurses by its very practice. We describe a form of clinical supervision particularly appropriate for this promotion – mutually supporting, descriptive supervision – elaborated as the paper progresses. As there are two of us, two distinct voices can be heard in this text. This is in keeping with an underlying imperative of the paper that each voice should be heard in its own right: that mutually supporting, descriptive supervision is all about hearing what a nurse has to say – without an overlaying of blinding assumptions.

Setting the scene

In 2001 we worked together to provide an RMIT University postgraduate course titled 'Clinical supervision as reflective practice' for nurses working at the Austin and Repatriation Hospital in Victoria. The course required participants to look at (reflect upon) themselves as professional nurses as well as to reflect upon various modes of clinical supervision.

The course exemplified the three determinants of mental health identified in VicHealth's *Mental Health Promotion Plan* for 1999–2002: increasing connectedness and belonging, reducing discrimination, and maximising economic participation. Many participants had received no formal education for some time. They were encouraged to value their expertise and insights and to concentrate on their professional worth. They came to recognise, and were reminded, their everyday analytical skills were transferable to client interactions: that critical analysis could sit comfortably with an appreciation of the mental health needs of their clients. Moreover, they came to see this critical analysis was a necessary aspect of their own 'mental' health: a shared analysis that required them to listen carefully to others – just as they were listened to.

For specialist mental health nurses there needs to be a new way of increasing the connectedness and belonging that once existed in institutions and within the profession. The rise in mental health consumerism sees a concomitant need for nurses to be more accountable to their clients. Often, nurses working in specialist mental health areas commence employment at a base grade, having to prove themselves to other professionals who are unaware or misinformed of their educational foundations. In this sense, they are discriminated against. This leads to a feeling of powerlessness, a feeling that is often transferred to clients. And sometimes, for various reasons, something more is transferred to clients – for example, aggression (Quintal, 2002).

Paradoxically, more experienced nurses sometimes feel they are 'lacking if they learn', so are coy or ambivalent about any form of professional development. There needs to be a vehicle wherein the three determinants of mental health can be addressed: an increased connectedness both with consumers and within the profession; a reflection on the discrimination experienced and a maximising of economic participation through increased job satisfaction. Mutually supporting, descriptive supervision is offered, here, as this vehicle.

A number of factors in the changing health care environment have affected specialist mental health/psychiatric nursing practice in recent times (Thomas, Brandt & O'Connor, 1999). It is critical that nurses adapt to these factors in order to remain relevant and 'whole'. They have traditionally cared for a vulnerable population and it is suggested to provide effective care in the changing environment, they must care for their own mental health. This attention to their mental health, we would argue, should be premised on a reassessment of competencies and skills.

The national mental health reform agenda saw the closure of the large mental institutions by the mid 1990s in Victoria, and progressively and at varying times in other states. Along with this came the mainstreaming of psychiatric services and also the expansion of community based care. Nurses within these services no longer had their traditional reference point or traditional experience base and career structures. The institutions had previously operated on a hierarchical structure, providing nurses with the opportunity to find their interest or satisfaction levels working in wards with varying levels of patient acuity. Responsibility for clinical decision-making was attributed to a well-defined order within the management structure.

The need now to manage consumers in the least restrictive manner (Mental Health Act, 1986, Victoria) has resulted in increasing levels of acuity in consumers in inpatient units, with shorter lengths of stay. Community specialist mental health nurses are thus also working with more acute clients; crisis intervention and community casework have accelerated rapidly. The consumer population is also increasingly complex with a marked rise in co-morbidities (for example, illicit substance use) and level of risk, including that of violence (McGihon, 1999). Psychiatric nurses from the traditional institution bases rapidly became community mental health nurses and are now often required to make clinical decisions on their own. This is particularly the case in rural areas where the supply and distribution of other key mental health professionals, including psychiatrists, is often not readily available or accessible.

Due to the increased acuity, violence and self-harm, there is a shift in focus from the primary mental illness to management of behaviours displayed. The tendency is to look for a 'quick fix' to explosive situations. This expediency can result in ignoring the core skills of nurses in prevention and education and the professional necessity to try to understand the underlying needs of clients vis-à-vis the needs of nurses. A passive or reactive role in client management often ensues.

This is the kind of management unwittingly perpetuated, for example, in an article by Sandra Quintal (2002). While Quintal notes that nurses' 'projection' may be an influencing factor in client aggression, and while she acknowledges the needs of clients, she gives no useful indication of how nurses should actively review, *within their practice*, their own feelings, attitudes, actions and statements. One senses the danger, in her approach of 'zero tolerance' coupled with an absence of clinical supervision, that consumers of mental health services will be increasingly feared and treated as a potential threat. It is this very attitude nurses are trying to dispel in the community at large. Quintal argues there is a 'desensitisation to violence'. There is however, evidence of exactly the opposite – one might suggest an over-sensitisation to the possibility of violence in those with a psychiatric diagnosis, particularly in the broader community. On the recent death of a Victorian man with schizophrenia who was 'unarmed and seated in a chair in his room … presenting no immediate threat', the coroner 'criticised the opinion expressed by police during the inquest that members should not show weakness'. He died following 'restraint asphyxia' (Butcher, 2002, p8).

To support the mental health needs of nurses, there needs to be a cultural shift to reflect recent physical and societal changes in relation to mental health. Nurses need to recognise and discuss future challenges and changing frameworks. This is not only important in terms of service provision and identity but also in terms of the recruitment and skilling of new nurses: specialist mental health nurses or otherwise. Skills and competence must somehow be passed on to coming generations of nurses; skills and competence in recognising consumer needs, and skills and competence vis-à-vis the mental health needs of nurses themselves. We believe clinical supervision is an ideal vehicle for this modelling and teaching.

Clinical supervision

Much of the diverse literature on clinical supervision is discipline-oriented. Different disciplines have different broad understandings of the process states:

> [i]n marriage and family therapy and in psychology, supervision is primarily discussed as a vehicle for teaching practitioners or students [...] As compared to social work, in these professions there is less discussion of the administrative aspects of most agency supervisors' jobs (Tamara Kaiser, 1997, p3).

Kaiser goes on to elucidate a differentiation of 'supervision' from 'consultation':

> *Supervision* is described [by Bernard & Goodyear, 1992] as an involuntary relationship in which the supervisor is imbued with the power to make decisions or take actions that affect such things as hiring and firing, promotion, salaries, or, in the case of a student, passing or failing. *Consultation* is a voluntary relationship in which the supervisee asks for help on a particular or a type of case and is free to accept or reject the consultant's advice (Kaiser, 1997, p7).

With regards to nursing, John Driscoll (2000) cautions:

> [w]hile it may be tempting to simply 'borrow' supervision knowledge from other disciplines, it is also worth considering that you will have different needs and circumstances in your own specialist areas of practice' (p4).

We suggest one of the needs of specialist mental health nurses is for them to give themselves permission to 'know': to be experts. This is not a need to be arrogant – rather it is a need to be competent. Do we not often hear that specialist mental health nurses 'put themselves down', denigrate their own worth? And if these nurses are expected to 'know nothing', then it follows there is nothing to learn. Negative attitudes (whether from themselves or from others) lead to negative expectations with regard to professional development.

To challenge this negative self-image, it is important to provide an ongoing learning environment where nurses constantly reflect on their skills and performance. Opportunities must be given for nurses to upgrade their skills, to participate in research and teaching and to actively collaborate towards excellence. They need opportunities for an interdisciplinary focus so their expertise is recognised and valued. This interdisciplinary profile can be achieved through participation in case conferences, seminars, journal clubs, research and multidisciplinary clinical supervision groups. Support is needed to hone skills and enhance competence. Reflection on fears, dynamics and attitudes is also necessary: the reflection that takes place in clinical supervision – the reflection that is not considered 'therapy' – the reflection without which any therapeutic intervention becomes questionable. Tania Yegdich (1998, 1999) takes pains to distinguish issues of personal and professional growth as well as remind us of the position of the consumer in our professional reflections on practice.

While acknowledging the benefits of an interdisciplinary approach in a number of professional development situations, our experience is that nurses are more likely to approach clinical supervision within their own discipline. This is borne out in a recent U.K. study of nurses:

> Sixty per cent (60 out of 100) of the respondents stated that clinical supervision is provided on a one-to-one basis with an expert supervisor from the same discipline as compared to 11 per cent who have a supervisor from a different discipline (Veeramah, 2002).

We should note, for the less experienced in particular, it takes time to achieve an interdisciplinary voice – to gain interdisciplinary confidence.

As well as broad disciplinary distinctions regarding the purpose of clinical supervision, the term itself embraces several concepts, not all of which are related. For example, there are those who see clinical supervision as a form of overseeing of the practice of a clinician. This kind of supervision often involves a complex description of a 'case' and examines interventions and consequences – much as you would see in a case conference, or case management meeting. There is a blend of education and sharing or imparting of expertise. There can be directive and non-directive approaches to this kind of supervision. The supervision can be facilitated in individual or group settings. Groups may consist of peers of more or less the same experience, or they may be facilitated by someone considered an expert. Furthermore, groups may be closed (the same participants) or open to whoever wishes, or is required, to attend.

Another form of clinical supervision consists of participants reflecting upon themselves vis-à-vis their interactions with clients. This approach largely hails from the post-Freudians, utilising some of the terminology of psychoanalysis (for example, transference, countertransference and ego defence mechanisms). The supervision process mirrors or parallels the counselling interaction. The learning occurs through modelling the supervisor and the gaining of insight to one's professional persona. This form of clinical supervision can also be facilitated either in a group or individually, and either directively or non-directively, depending upon the style of the supervisor. There can also be more 'conscious' modes, in line with rational-emotive therapy or cognitive behaviour therapy. This broad approach is premised on the observation one will be a more effective practitioner if one gains some understanding of oneself:

> Understanding another begins with understanding oneself. Psychiatric nursing has adopted Rogers' (1961) humanistic philosophical view of self-awareness. To effectively use the self as a tool, nurses must possess knowledge of their personal response patterns, strengths, and limitations (Eckroth-Bucher, 2001).

Both broad approaches can be useful for nurses in promoting their mental health, because they stimulate reflection on practice and hence aid the development of professional responsibility. Professional responsibility implies maturity – the maturity, for example, that enables Paul Smith to give an excellent first person account of his experience of clinical supervision and to bring out its positive effects on his mental health (Smith, 2001).

Mutually supporting, descriptive supervision

The approach to clinical supervision introduced here sees the reflection based on a detailed and careful *description* of interactive processes. This is mutually supporting, descriptive supervision. This form of supervision does not seek to explain or interpret; it does not look for causes or reasons. Rather, it enables clinicians to gain a clearer view of themselves in their interactions with consumers. It acknowledges the fact that a consumer (and others for that matter) 'sees' a clinician: that an interaction, far from being a one-sided objectification of the consumer, is composed of (at least) two primary parties, each of whom views the other. It is mutually supporting because all parties of the supervision activity are assisted in gaining clearer insights on their own reflective processes.

This form of description can trace many of its roots (procedural as well as ethical) to the work of a number of thinkers. On the one hand, it owes credit to thinkers who sought understanding through an attitude of openness and receptivity, both towards oneself and to others. Edmund Husserl and Simone Weil are fine exemplars of this *attitude*. Husserl, who developed his transcendental phenomenology as a response to the shaky ground of 'objective' (and totalising) science; Weil, who as a social and political philosopher/activist, fought for the rights of the less privileged via a sustained critique of mechanisms of social control. Mutually supporting, descriptive supervision owes this attitude to people like them. It also owes credit, in some important respects, to contemporary critical philosophers, such as Michèle Le Dœuff, who promote a hypercritical approach to social issues, an approach that uncovers duplicitous assertions.

Differently from the first approach described above, this form of supervision does not commence with the 'case' or client, but rather proceeds from the standpoint of the clinician, *who stands in a relation to the client*. Differently from the second broad approach, there is no emphasis on psychological or psychoanalytic frameworks, although these are not ignored. The approach focuses primarily on the words spoken by the nurse, examining their logical significance and coherence. Thus it is largely a descriptive approach, not seeking to ascertain causes, but rather *leaning towards* a better view of the nurse's actual involvement in an interaction. There is a purely logical analysis of the interaction.

This form of supervision can again be facilitated either in a group or individually. However, because it does not rely on any particular added clinical expertise, it is more comfortably undertaken in a peer group, where there can be several foci of analytical sight. Mutually supporting, descriptive supervision is distinguished from forms of clinical supervision that rely upon a 'leader' or 'knower' or 'expert' to direct the group. Here, it is the individual nurse who, being accountable, brings together others or another in order to facilitate a 'mutual', objective analysis of the words spoken by the nurse. The approach does, however, acknowledge the psychological premise that nurses are more likely to be effective, 'mentally healthy' role models when they demonstrate a non-dependent and self-directed attitude: a demonstration of good 'mental' health in taking responsibility for themselves (as members of society). A leaning towards group supervision also sits well with the observation that leadership dynamics vis-à-vis dependency are well addressed in a group setting: a setting that can mirror what often happens in a team situation. Having stated that, we do however concur with Alison Morton-Cooper and Anne Palmer (2000) that 'it is beneficial to have some knowledge of group dynamics and how groups work' (p177).

We see then, that mutually supporting, descriptive supervision is formed on a complex ground. First, it acknowledges the professional and legal accountability of each nurse: there is no other supervisor but the nurse her or himself; it acknowledges the fact that nurses work independently with clients, whether or not they also work in a team situation. Secondly, it requires a special form of attention from the nurse and peers, the form of attention well encapsulated in the words of Simone Weil:

> Attention consists of suspending our thought, leaving it detached, empty and ready to be penetrated [...]. All wrong translations [...] and all faulty connection of ideas are due to the fact that thought has seized upon some idea too hastily and being thus prematurely blocked, is not open to truth. The cause is always that we have wanted to be too active; we have wanted to carry out a search (Weil, 1951, quoted in Miles 1986, p5).

Weils' thoughts are more than apt for the context of this essay. The very last entry in her journal reads: 'Nurses' The word is spelled in English with no punctuation' (Gray, p207). She had earlier suggested sending nurses to the Front as a reminder to French and allied soldiers of 'the values for which they were fighting and the homes which they were defending' (Miles, 1986, p23). An idea that led de Gaulle to label her 'mad' (Gray, p190; Miles, p30), a label that would not be much appreciated in our current age of post-feminist politics. The suspension of thought proposed by Weil is reminiscent of the epoché of Edmund Husserl, where the 'natural attitude' is constantly reevaluated. That is, *just because* the objects of our perception are taken for granted, we must be ever mindful of what we may be missing. Thirdly, also from Husserl, knowledge of others begins with knowledge of ourselves, the observers:

> The genuinely universal epoché of psychology destroys the illusion of the *mutual externality of souls*: the mutual internality which extends out from the psychologist determines the course of the psychological investigation (Fink, 1970, p397).

The 'psychologist', in this case, is merely the person who seeks to gain 'an objective view' of another. This is not 'understanding' in the Rogerian sense earlier described, although there is no reason the two cannot sit comfortably together.

There are specific psychological considerations one should not ignore. It is in the process of facilitating clinical supervision for nurses, for example, that one encounters some of the difficulties associated with group leadership. If one established oneself as the group leader then there would be an unspoken expectancy regarding the focus and expertise of this role. If this focus were to persist, then what would that mean for the other group participants? Would a sense of powerlessness or dependency be encouraged? Is it not enough to merely state this problem or assert that the power in the group would be equally shared, and promise a finite timeframe for the presence of the facilitator? One has to somehow act out this equality – encourage an environment where all participants are equally valued, an environment that can be translated to client/nurse interactions.

Through mutually supporting, descriptive supervision, nurses come to see that the 'mental health' distinctions between their clients and themselves are artificial (though in many professional respects, necessary). They learn from themselves and their clients they are not themselves immune from mental health problems. They learn this through sustained critique of the words they use. This attitude of critique is transposed to ensuing patient interactions. Thus some of the counselling statements that can be too easily ridiculed as being evasive or even patronising, are given a firm basis of credibility: 'I hear you saying…'; 'Can you tell me more about that...?' The counsellor/nurse/interactor needs to hear rather than tell, to listen rather than to judge. We can hear the ethical imperative in this kind of approach. There is also a sense of allowing others to speak fully, in their own terms, without casting quickly-conceived judgements or interpretations. The reference to Weil becomes more poignant.

Michèle Le Dœuff is also strong on this point: for her, '[t]o *stand before* is to hear, to *stand in for* is to block' (Nicholls, 2000, p158). Furthermore, apropos the group approach, for Le Dœuff, '[t]o hear is to be a person among people: we don't hear a 'univocalization', but a multiplicity of voices' (Nicholls, 2000). In terms of an analytical or critical approach to ourselves as thinkers in an interaction, the words of Le Dœuff strike a resonant cord:

> Thought is thought about something: is this something properly understood? Does one's thinking reflect the current state of the problem? Does it show a sufficient level of information? Has it

> questioned itself enough? Is it accompanied by critical thinking? Does it open up new perspectives? When questions of this type can be asked of thought, it can be regarded as thought and not just as a verbal opinion or a quiet delusion (Le Dœuff, 1991, p160).

Mutually supporting, descriptive supervision allows this in-depth examination to take place in a mental health setting. It further acknowledges that nurses are constantly analysing their thinking with regard to their professional responsibilities toward their clients. The formal supervision session allows their own analytical skills to be honed via the multiple perspectives of peers. They begin to see in acute terms their own attitudes to themselves and to those to whom they are also accountable. And they see clearly the attitudes and actions of others toward consumers of mental health services.

Mutually supporting, descriptive supervision does not ignore, but rather highlights the fact that nurses are expected to meet certain competencies in their practice and be legally and professionally accountable *as individuals* – that they must constantly evaluate their practice as it is unfolding. When a nurse is working with a client, the nurse is fully responsible for her/his side of the interaction. Practice in this sense is truly independent and visible.

Conclusion

In our experience, people with mental illness or mental health problems often claim to be misunderstood or 'not listened to' by others. This sentiment, also expressed by specialist mental health nurses, is directly associated with connectedness and belonging. 'Not being listened to' is a form of dismissal that can lead to feelings of alienation. Feelings of alienation, in turn, can lead to isolation. One could suggest it is an increased appreciation of these factors that has led to the current valuing of consumer perspectives in mental health. Perhaps it is now time to acknowledge we are all consumers, in that services are supposedly available to each of us. And which one of us has never felt unheard, dismissed, alienated?

Psychiatric nurses of the past were not supposed to have evident mental health needs. If they exhibited 'problems' they were vulnerable to strict monitoring. The latter, surveillance, was a form of marginalisation and some quietly disappeared from the scene. Perhaps it is this fear of surveillance, and what it might imply in a mental health setting, that has resulted in a suspicion of clinical supervision in specialist mental health nurses. If I discuss my 'feelings' towards a client, admit my thoughts, needs or countertransference (depending on the approach taken), then I might be judged as being 'like' the client. Resistance to clinical supervision may then be resistance to identification with the client. We can see how this resistance could lead to further alienation for the client.

There is no doubt discrimination is an important determinant in the identity of specialist mental health nurses. As a body of numerous professionals, they are readily aligned, in the public imagination, with the perceived inadequacy of mental health services. They are blamed for factors over which they have little or no control such as poor facilities and lack of resources. Further, they are often expected to function as if they were caretakers during the absence of other professions. This attitude is a hangover from the past where psychiatric nurses were considered to be wardens or turnkeys – linked in the public imagination with the police in the apprehension and detainment of threats to society. It is within this general scenario these nurses are attempting to reframe their identity as highly skilled supports to police and others. In this regard there is an imperative to claim equality with respect to their professional needs.

Clinical supervision is thus a right as well as a professional expectation. Nurses will sometimes state they cannot attend clinical supervision because they are required to be 'on the ward' or attending to their clients. Members of other professions will, on the other hand, assert the expectation and their right to clinical supervision and other forms of professional development (as of course, they must do).

Nurses should, of course, be viewed equally with other professions in the economy of mental health services. Increased support and satisfaction levels of nurses in the workforce would go some way to addressing current shortages experienced in the face of rapidly expanding mental health services – an expansion necessary to meet the growing demand. This paper has been written on the premise that both support and satisfaction levels can be achieved through active involvement in clinical supervision, specifically mutually supporting, descriptive supervision.

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22 The Employee Health Committee – promoting holistic workplace health

Employee Health Committee, Upper Hume Community Health Service: Shandell Blythe, Carolyn Ellis, Loretta Foster, Frank Johnson, Paula Mobach and Tanya Paech

This paper describes the history, development and activities of an employee health committee established by the Upper Hume Community Health Service (UHCHS) in Wodonga, Victoria. The Committee has been operational for approximately 18 months and comprises six volunteer staff members. It is the latest initiative of UHCHS' *Workplace Health Promotion Program* (WHPP). The Committee offers a health promotion and wellbeing service to UHCHS staff members, drawing on lessons learnt from an earlier, unsuccessful program. It utilises the social model of health as a framework and as a means of focusing on the strategies of social connectedness and capacity building. Several diverse activities have been implemented since the inception of the Committee. These are described here, including our experiences in planning and implementing them, along with ideas about possible future activities. The challenges of evaluating such programs are also briefly discussed, and some preliminary outcomes presented.

Upper Hume Community Health Service (UHCHS) – who are we?

The head office of UHCHS is based in Wodonga, north east Victoria. Our area includes the municipalities of Wodonga, Indigo, Towong and the Kiewa Valley portion of Alpine Shire. Our service area is part of the Department of Human Services Hume Region. As well as five office sites in Wodonga, UHCHS has outreach sites in the towns of Beechworth, Yackandandah, Mt Beauty, Corryong and Tallangatta and employs approximately 70 staff of whom 72% work part-time and 20% work from outreach sites. Our staffing structure consists of seven key service areas:

- community health and families
- administration and finance
- alcohol and other drugs
- youth
- mental wellness and rehabilitation
- strategic development
- counselling and support.

The scattered nature of our office sites and employees makes the task of connectedness and total staff wellbeing all the more challenging. Also, members of some teams are not all located at the one site, making the simple task of a team meeting a logistical nightmare. For example, the community health/families and youth teams have staff located at up to five different sites at distances of up to 120 km from their Wodonga base.

Our vision

UHCHS recognises health as a complete state of physical, social, emotional, mental and spiritual wellbeing and not just the absence of disease. The Service strives to become an acknowledged leader within the social model of health, by:

- the development, delivery and evaluation of rural services
- sharing best practice, skills, knowledge and expertise
- taking a visionary, partnership approach to meeting health and social needs
- advocating of behalf of its communities.

Our mission

Our mission is *Working together towards healthy communities*, by:

- facilitating, developing and providing a diverse range of quality and accessible services
- empowering individuals, communities and staff to maximise their potential for healthy, happy and fulfilling lives.

The social model of health is central to achieving the UHCHS mission and underpins all planning, strategic relationships and work practices. The model requires the determinants of an individual's health status be seen as social as well as individual, and a range of social and environmental factors be seen as impacting on the health of both individuals and the broader community (Wilkinson & Marmot, 1998). We acknowledge and embrace the rich variety of lifestyles and human experience within our communities and the importance of supporting and nourishing a strong sense of connection and belonging for people living in them. We strive to achieve this with a service that is flexible, accountable, consumer driven and accessible to a broad range of individual and community resources.

Our first attempt – Workplace Health Promotion Program (WHPP)

WHPP was developed between 1996 and 1999. During this time, linking into workplaces was seen as a key to delivering a health promotion message to the wider community and audiences not previously reached. After consultation with VicHealth's *Healthy Industry Program*, a business unit was formalised. Its mission was to deliver professional, flexible and comprehensive approaches to workplace health promotion in a market-driven, fee for service environment. The aim of the program was to assist workplaces become healthier. This would benefit individuals and their families, the organisation and consequently the community.

The initial program modules offered were Quit Smoking, blood pressure checks, diabetes and cholesterol monitoring. While these modules enabled discussion beyond issues relating to physical health, WHPP acknowledged the difficulty of addressing social and emotional wellbeing and the more subtle issues impacting on workplace health. Subsequently, modules on skin cancer, manual handling and back care, stress management, and alcohol and other drug issues were introduced. Feedback on these enabled management to act on relevant issues for employees and develop a better understanding about how to support their needs.

The aim of WHPP was to facilitate increased morale and productivity within the workforce with the desired result of reduced absenteeism, staff turnover and workers compensation claims. It was in this climate that UHCHS chose to develop a workplace health plan of its own and become a client of its own business unit: it was viewed as important to 'walk the talk' of workplace health promotion. Initial attempts to develop workplace health within UHCHS, however, were not successful. Although the project had support from the Board, it was characterised by management-driven activities and adherence to a traditional medical model. It was rejected by staff members as not reflecting their needs and lacking consultation. From this time, the process broke down and for 12 months there was no further activity in this area. (In retrospect, this was a useful experience as it reinforced the need for the Employee Health Committee to be owned and driven by the employees.)

Introducing a different WHPP approach - the Employee Health Committee

Interest in workplace health within UHCHS was rekindled primarily by extensive structural change within the organisation, following the appointment of a new Chief Executive Officer. According to anecdotal reports, changes significantly improved employee health and wellbeing, especially in areas such as communication, information flow, recognition of each individual's contribution to the workplace and the community, and the opportunity to be actively involved in the future of the organisation.

A comprehensive strategic planning process was undertaken involving all staff members. Interviews were conducted with key stakeholders and community groups, and an intensive two-day planning meeting was held – attended by almost all staff members, plus the CEO and several Board members. It was out of discussions at this planning meeting that the Employee Health Committee was eventually established, with a call for additional members. Involvement in the group remains voluntary; meetings and most activities are held during staff members' work hours, however no additional work time is allocated to members.

Purpose and principles of the Employee Health Committee

At its first meeting, the Committee formulated statements of purpose and principle based around the social model of health, in keeping with the mission of UHCHS. The purpose of the Committee is to develop and provide services and programs to:

- support and value employees
- promote employee health
- facilitate connectedness and the growth of social capital.

The underlying principles of the Committee are:

- ownership
- consultation
- sustainability
- innovation.

These statements guided the group away from a medical model towards more socially-based activities that increased a sense of belonging and connection, and hopefully better psychological wellbeing. Increased social connection and a sense of belonging are factors that enhance levels of social capital for individuals and organisations. Social capital has been described as 'the glue which holds people together', and which facilitates individual and community wellbeing (Kawachi, Kennedy & Glass, 1999, p1187). The Employee Health Committee is not a social club. We have been very clear our purpose is to promote health. Any social activities are provided as a means of achieving this goal, rather than as an end in themselves.

What have we achieved?

Staff room facilities

Our first project was to work with management to improve facilities available for staff members. This involved the renovation and refurbishment of office space as a staff room at head office in Wodonga. Until this point there was no such facility available and we believed we could not realistically promote social connectedness and cohesion unless there was a venue for it to occur. This project fulfilled the Committee's purpose and principles by ensuring ownership and sustainability. Observed benefits include more people taking lunch breaks, more opportunity for meeting and networking with other employees and a noticeboard promoting upcoming events, staff achievements and jokes! All these have potential to improve social connectedness, reduce occupational stress and promote a sense of belonging and being valued – all of which may in turn improve psychological wellbeing.

In addition, staff members were encouraged to use the facilities and take an active role in their ongoing improvement. A competition to name the room was held and at an official opening, the CEO cut the ribbon and presented the prize to the successful staff member. These activities promoted further social connection and sense of ownership, and gave an official seal of approval to the Committee's activities. At Christmas time we provided every staff member with a personalised Christmas card (or a 'thanks for being part of the team' card) and a health and wellbeing calendar - designed to give staff a sense of being valued by the organisation and again, to promote a sense of belonging.

Volunteering

Volunteering provides a sense of wellbeing and value. Through the act of doing something for others, it reinforces social connections and the sense that one is part of something bigger than oneself, and has a role to play in wider society (Wilson & Musick, 1997). The Committee sought to encourage volunteering in two ways: volunteering and fund raising. Firstly, we encouraged staff members to volunteer as regular blood donors – an option not involving a lot of time, or inconvenience to others if cancelled. Any interested staff members can take time out from normal duties once every ten weeks to donate blood without loss of pay. An agency minibus transports the staff members (the local blood donation point is a 15-minute drive away), and we provide lollies and games to increase enjoyment and lessen any tension associated with the pending procedure. Staff members are made aware of the life-saving nature of their donation and the value of this to others in their community. We value-add to the activity by incorporating a competition for the most consistent donor over the course of each year. The recipient of the 'Blood worth bottling' award receives an engraved shield as a gift at the staff Christmas party.

Secondly, the Committee supports some fundraising activities for other organisations, most notably 'Australia's biggest morning tea'. This is an opportunity to foster social connection, belonging and value among staff members while supporting a worthy cause. Competitions and prizes attract as many people as possible to take advantage of both a social activity and an opportunity to do something for the wider community. Staff members mix with colleagues they have never met before, increasing a sense of connectedness within the organisation and reinforcing their role and position in it. The social activity is the means to the end of improved health and decreased stress.

Stress reduction and social activity

The Committee also creates opportunities for more traditional health promotion and stress reduction activities. For example, we pay for quarterly visits by a masseur, and all staff members can access a 15-minute relaxation massage in the workplace, free of charge. These sessions are very popular and feedback from staff particularly mentions a sense of being valued by the organisation. Staff members appreciate having the stress of their work recognised by management, and followed up with assistance to manage it. Flu injections and time off to attend for them are also paid for. The Committee has planned several future health promotion sessions to be held as part of staff meetings.

The Committee also held a social event outside of work hours, which was poorly attended but much enjoyed by those present. This has reinforced the importance of pursuing activities within work hours. Many staff members live in towns surrounding Wodonga, and face a return trip of up to 150 kilometres to get to activities in Wodonga on a weekend or a long journey home in the dark if staying after work.

'Walking the talk'

A further strategy we use is that of 'walking the talk' ourselves –basically doing the things we ask others to do, and promoting a positive and healthy workplace at all times. Committee members aim to portray the working environment in a positive way, and to promote discussion of solutions to problems rather than negativity. We aim to attend all committee activities and actively encourage others to do so. We maintain an open and friendly attitude – seeking feedback from staff and following up on their ideas. It is difficult to measure the outcome or success of this approach, and we have not sought specific feedback on it from staff, but it is a way of working we intend to continue – if only because it promotes the psychological wellbeing of Committee members!

What have we learnt?

To adhere to its underlying principles of ownership and consultation, the Committee disseminated a survey to staff members asking various questions, particularly in relation to staff knowledge of the Committee, whether staff members had participated in any of its activities and whether or not they found the activities beneficial. Suggestions for further activities were also sought.

Forty per cent of surveys were completed and returned. Ninety eight per cent of staff indicated they had a very good understanding of what the Employee Health Committee aimed to achieve. Eight five per cent of the staff who demonstrated a good understanding of the Committee mentioned the words 'employee health' and 'wellbeing'. Seventy five per cent of staff members who participated in the survey stated they had attended one or more of the activities organised by the Committee, and others who had not attended gave the following reasons:

- lack of time to attend
- the activity was not held on a day that a part-time employee worked
- other work commitments had taken priority
- working in an outreach site
- just commenced employment with the organisation.

When asked to comment on what staff members thought of the activities they had participated in, 97% gave positive feedback. The other 3% were those employees who had just commenced in their positions with UHCHS, so were unable to comment. Positive feedback included:

- they enjoyed social interaction with other staff
- it contributed to their individual wellbeing
- they felt the organisation cared about them
- the activity provided time away from their desk
- participating in the activity allowed them to 'practice what they preach'
- the activities gave them opportunity to relax
- they felt valued as an employee
- a sense they were helping others
- an opportunity to know work mates as people rather than colleagues
- opportunity to have fun at work
- a sense of belonging to the whole organisation.

Further activities staff members would like the Committee to promote included: walking, yoga, meditation and other ways to alleviate occupational stress, strength training, an indoor pool and the celebration of employees' birthdays. The idea of taking six weeks annual leave incorporating two weeks of unpaid leave was also suggested, along with more opportunities to socialise with staff outside of work hours.

In future evaluations the Committee will include questions addressing issues for part-time employees and whether these have an effect on attendance at activities. It has also been raised with the Committee that some activities have been inaccessible to outreach staff due to the distance they would need to travel to participate. We need to address this as we wish all staff members to feel included, valued and that they have equal access to Committee activities.

While the Employee Health Committee is dedicated to evaluating its outcomes, we do not have the expertise to adequately evaluate whether staff participation in Committee activities has had a positive effect on their psychological health and wellbeing. We are considering the possibility of conducting a research project that may be able to address this issue more thoroughly.

What special insights can we leave with you?

Our prime comment is that any initiatives such as the Employee Health Committee *must* be *supported* by management, but not *driven* by management. The first project was viewed by staff as being controlled and directed by the CEO, and this seemed to inspire either anger or apathy towards it. The Employee Health Committee is now run *by* staff members, *for* staff members. All have an opportunity to contribute ideas or suggestions, to observe their colleagues planning and implementing programs, and to discuss the principles and philosophies behind the choice of activities. The activities of the Committee are, however, given strong support by the CEO and management team, and are funded in the organisation's budget. Without this support, the group could not survive, but without our own autonomy and ownership by the staff members, we would not be relevant or useful to our fellow employees or the organisation. It is worth noting, the majority of Committee members are employed part-time and it can be difficult to arrange common meeting times to plan for future activities or organise and conduct current activities.

Our methods are consistent with the guidelines for developing healthy workplaces promoted by the World Health Organization (1999). The seven factors WHO identify as being crucial to the success of workplace health promotion (Box 1) are those we embrace and try to achieve. Although we can clearly see and celebrate our achievements, we know we have a long way to go, especially in terms of addressing access and equity issues for our rural and part-time staff – trying to connect 70 people based in 10 different work sites.

Our experience has been one of trial and error, and clearly one that is ongoing. We will continue to seek feedback from staff and management to determine the efficacy and acceptability of our initiatives, and we will continue to seek creative ways of improving employee health in a holistic way – addressing psychological, social and physical health issues via strategies of social connectedness and capacity building.

Box 1

Seven factors for success in workplace health promotion (WHO, 1999, pp18-29)

- Active support by senior management
- Worker participation at all stages
- Flexible content determined by the needs of workers
- Links with community services and activities
- Complement individual behaviour change with organisational change
- Run programs in company time
- Voluntary participation

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23 Developing a mental wellness program in an aged care facility: a trial project

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Internationally, there is growing awareness about the prevalence and cost of mental illness in the workplace. Mental ill health in the workplace is estimated to cost UK employers £6.26b each year in lost working days alone (Lancaster & Burtney, 1999). In 2000, The New Zealand Mental Health Foundation commissioned a project to develop policy and implementation guidelines for a mental health and wellbeing workplace program. Subsequently, one strand of this program is a trial project in a large aged care facility in Auckland. Although the project is still in an early phase, a number of key themes have already emerged and these are reported here.

Background

The goal of The New Zealand Mental Health Foundation program is to optimise the quality of working life for staff by creating a mentally healthy work environment. The trial of one strand of the program started in August 2001 and the Foundation's involvement in the project has been funded for two years. The philosophy of the Foundation's program is that in order to maximise the quality of life for staff, it is necessary to:

- Identify the barriers to optimal mental health in the workplace
- Create a plan of action to address those barriers
- Create organisational ownership of the program
- Implement a program of evaluation.

Further, the evaluation of the program needs to:

- Ensure planned initiatives are implemented and address identified barriers
- Monitor the workplace to ensure additional barriers are identified and integrated into an action plan
- Assess whether the program is meeting identified outcomes.

Choosing the project site

The trial project is currently being implemented in a large aged care facility in Central Auckland – Caughey Preston. The facility has a hospital and two rest homes on site. It has 188 staff and 238 service users. Most rest home residents are women. This organisation was chosen as the trial site for the project because it was identified as a workplace with a number of positive initiatives already in place, such as a robust orientation program. The Foundation reasoned that for a trial project, it was better to work with an organisation already committed to enhancing the quality of working life of their staff.

The CEO and Board of Caughey Preston were excited by the project and provided their commitment to supporting its objectives. The organisation is looking for ways to address industry-wide recruitment and retention issues and it was felt a project like this could give them an edge on similar workplaces competing for the same pool of staff.

Securing participant commitment

Although the project had senior management support, to succeed, middle management and staff had to also 'buy into' it. This process was initially started with a presentation to middle management that included a question/answer session. It was hoped giving them the opportunity to question the project and air any concerns would encourage their support.

The project leader attended staff meetings throughout the site, during the full range of shifts, so as many staff as possible had an opportunity to be personally informed about the project and to ask questions. Where possible, staff members have been kept fully informed about the project's progress through meetings, staff newsletters and through memos where appropriate.

The establishment of a working group was an important step in advancing the project. It consisted of eight people selected on the basis of their interest in the project and cross-section representation of staff.

The project

The initial phase of the project involved an organisational needs-analysis with the purpose of identifying existing barriers to employees' optimal mental health. A qualitative process consisting of a series of focus groups and interviews was implemented as follows:

- Eight one-on-one interviews conducted with middle managers
- Seven focus groups with staff, structured to ensure a cross-section of staff, were conducted. Quotas for the groups replicated the demographic profile of staff as closely as possible. Supervisors were interviewed in separate groups to staff members.
- Three focus groups of clients were also conducted to ensure their perspectives were included. As they see staff everyday in their work environment, they had valuable insights to contribute.

Results

A content analysis of the interviews and focus groups identified the following key barriers to employees' optimal mental health:

- Poor communication between staff members
- No formal support system for staff with personal or work-related problems
- The negative impact of the high use of bureau staff upon permanent staff
- Fragmented organisational culture
- Lack of cross-cultural understanding among staff.

These results were disseminated to senior management, then to middle management and then to all staff members. Opportunity for feedback was provided. After priority areas had been identified, an action plan to promote mental health in the workplace was developed through a consultative process with staff and management.

Action plan

The action plan is currently being implemented and has been structured in six-monthly stages so progress can be monitored regularly against established objectives. Responsibilities for implementation are being shared across various people and teams throughout the organisation including the working group.

To ensure continued support for the project by staff, the working group decided there had to be tangible benefits for staff sooner rather than later. Particularly as benefits of the more strategic objectives, such as reviewing recruitment procedures and revising communication protocols, were not going to be immediately beneficial to staff. The following initiatives were consequently implemented in the first six months:

- A self-care strategy training program for staff
- Budget advisory service presentations for all interested staff
- Fridays declared 'mufti' days when staff can choose to wear their own clothes rather than a uniform.
- A project launch to coincide with National *Absolutely Nothing Day* (New Zealand Mental Health Foundation, 2002). Staff members were treated to a barbecue and an additional 15-minute break.

Key insights to date

Although progress has not been formally evaluated as yet, the following themes are emerging.

Strong leadership paves the way
Management impact on the progress of the project and on the extent to which staff 'buy into it' cannot be underestimated. The unit manager who has been most supportive of the project to date is 'selling' it to her staff. Her staff members have a higher attendance rate at related training courses and seem to have a higher awareness of the project than other staff on site. Members of the working group have also been instrumental in encouraging their co-workers to support the project and participate in initiatives promoted by the project.

Sometimes it's necessary to swim upstream
It has become evident a project like this will challenge '*the way things are done around here*'. In reality, this means it is necessary to evaluate what is realistic as well as what is desirable. This might mean ideal objectives are shelved for more pragmatic alternatives. Pushing too hard can create resistance that it is difficult to overcome.

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Emphasise processes not people

The culture of the organisation is divisive. This has meant that when issues emerge from the project, it is essential they are put into the context of a systems approach - *what* needs to change rather than *who* is at fault.

Creating opportunities for ownership

As the project leader is external to the organisation there has been a temptation for the organisation to deflect project ownership. It is also sometimes difficult for the project leader to stand back rather than exert control. Ownership must stay firmly with the organisation to reduce the risk of the project falling over when the support of the external project leader is withdrawn. This risk is being safeguarded against by the project leader restricting her role in the development of action plans to one of *advice*. Further, once the project is firmly established, she intends to hand leadership of the working group over to an internal person and to attend in a supportive capacity only.

Conclusion

Finally, an evaluation strategy has been in place throughout the project to monitor and review progress against established objectives. Although the project is in an early implementation phase, progress and informal feedback is promising. As Robyn Northey, CEO of Caughey Preston says:

> The project has put on the table some issues of organisational culture previously hidden. We can now talk about them and begin to make changes in an open and collaborative way (2002, pers. comm.).

The first formal evaluation report is due for completion by October 2002.

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24 Staff wellbeing - a key ingredient for organisations promoting mental health

Anne Boscutti

This paper explores the importance of staff wellbeing as a component of mental health promotion strategies aimed to enhance organisational practice and service delivery. By reflecting on examples of practice in youth, community and education settings, the integral role played by staff wellbeing in each is illustrated.

Introduction

Historically, organisations have addressed staff health and safety within the context of occupational health and safety guidelines. More recently, some industries have acknowledged that staff wellbeing plays an important part in promoting productivity. Paauwe and Richardson (1997) identified that in the health sector, staff involvement was important in linking strategic change with service development for effective service re-orientation.

This paper examines the central role staff wellbeing plays in the design and implementation of mental health promotion strategies in a variety of workplaces. In the case of education or health-based mental health promotion initiatives, it is argued a whole-of-organisation approach should be applied that includes organisational and workforce development strategies as well as client interventions. To illustrate these points, three organisation/service contexts are discussed:

- an initiative drawn from the Health Promoting Schools Framework (WHO, 1996)
- the Innovative Health Services for Homeless Youth Program (IHSHY)
- Dealing with Depression, a Victorian report on issues faced by primary care and mental health workers in metropolitan Melbourne (North East Mental Health Promotion Network, 2001).

Mental health promotion - the national plan

The *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health* provides a framework to orient workforces towards an understanding of mental health promotion (Commonwealth Department of Health & Aged Care [CDH&AC], 2000a). It also contains themes reflecting what many services (particularly primary health care, welfare services and school support services) have known and been working with at a common sense level for some time. The National Plan defines mental health promotion as:

> Any action taken to maximise mental health and wellbeing among populations and individuals. It aims to protect, support and sustain the emotional and social wellbeing of the population by promoting the factors that enhance mental health.... Examples include action designed to increase the connectedness and supportiveness of school or workplace communities (CDH&AC, 2000a, p6).

The National Plan profiles a framework of mental health promotion that is relevant across the continuum of mental health care and full spectrum of interventions. Different strategies may address the promotion of wellbeing for the entire population – people who are currently well, at risk or experiencing illness – or target specified groups within this range. Mental health promotion is distinguished from prevention, early intervention, treatment and rehabilitation by its focus on wellbeing as opposed to preventing or addressing illness. However, in practice, particularly in the areas of prevention and early intervention, there is significant overlap. Many programs and strategies impact on both issues simultaneously.

A population health approach is required in mental health promotion, as well as an approach that promotes social responsibility for health and wellbeing from within all sectors and settings of society. As identified by the WHO (1986) in its Ottawa Charter, the five main strategies of action for mental health promotion are building healthy public policy, creating supportive environments, strengthening community action, developing personal skills and re-orienting health services.

Several barriers and opportunities present when mental health promotion targets organisational development and service reorientation. Common themes in the evaluations of the innovative programs described here relate to fundamental success factors.

Health promotion and wellbeing in schools

The Health Promoting Schools Framework (WHO, 1996) encourages a multidimensional approach to working in the spheres of curriculum, school organisation and environment and community partnerships. It implies changes in organisational culture and challenges teachers to consider fundamental changes in the way they think about education. The framework broadens the core focus of education to include wellbeing as well as academic achievement.

Staff wellbeing has emerged as a key theme in the implementation of health promotion initiatives aimed at building resilience in young people in schools. In Australia, there have been several projects addressing the themes implicit in the Health Promoting Schools Framework, including: the *Health Promoting Schools Project* (Victoria); the *Gatehouse Project* (Bond, Glover & Patton, 1999); and the *MindMatters Project* (CDH&AC, 2000b).

The National MindMatters project and the Victorian Centre for Adolescent Health Gatehouse project have taken the concept of mental health promotion into school communities with a comprehensive 'how-to' guide and a range of resources. While both programs are targeting student wellbeing, the importance and primacy of addressing staff wellbeing has continued to emerge as a significant theme. In the Victorian Health Promoting Schools Project Evaluation (Deakin University, 2000) more than half the pilot schools identified staff health and wellbeing as their top priority for organisational development.

.The School Matters resource material in the *MindMatters Kit* includes a section on staff mental health and emphasises the importance of attending to it as part of a whole-of-school mental health promotion strategy. It identifies that:

> ...poor staff mental health or wellbeing has been cited as a major barrier to implementing mental health initiatives for students (CDH&AC, 2000c, p27).

If teachers are to facilitate mental health promotion, then they need to understand the importance of caring for themselves first.

In addition, teachers have identified they need to be well prepared and supported in order to provide appropriate role modeling and leadership for their students. Staff preparedness to address sensitive mental health issues as part of the curriculum (such as stress and coping, understanding mental illness, dealing with loss and grief, bullying and harassment) has been tempered by a lack of information, fear and stigma associated with mental illness in the community.

Health promotion and wellbeing in the health sector

The past decade has seen exciting innovations in Victorian mental health services for young people. Many of these could be considered mental health promotion initiatives by their focus on building the capacity of workers whose clients reflect high-risk populations. Common elements in these programs contributing to worker stress include circumstances in which client engagement is problematic, restricted communication and understanding between mental health services and primary care services, and limited resourcing of primary care services.

Challenges to staff wellbeing in the health sector are heightened in programs operating with scarce resources and servicing high-risk populations. A study of the relationship between supportive behaviours and burnout among mental health clinicians, found significant associations between burnout and supervisor support, colleague personal support, colleague professional support, therapeutic success, work pressure, administrative authoritarianism and client pathology (Brewer, 1995, p4100).

The Innovative Health Services for Homeless Youth Program (IHSHY)

This program is a good example of a mental health promotion initiative targeting high-risk clients. IHSHY was a joint commonwealth-state initiative developed in response to the 1989 Report of the Human Rights and Equal Opportunity Commission, *Our Homeless Children*. The program was funded to facilitate a shift in youth policy and service delivery – moving from a crisis response to homelessness, to an incorporation of early intervention approaches.

An evaluation of IHSHY highlighted the importance of management support of staff in contributing to the effectiveness, appropriateness and efficiency of the program in achieving its stated objectives (Success Works, 1997). IHSHY was found to be a highly successful program, with a major impact on service delivery for homeless young people and in those agencies where it was located. It was acknowledged that management styles varied and that:

> [this] variation had an impact on the capacity of the workers to influence decision-making processes and on the involvement of the community, and young people themselves in influencing service development (Success Works 1997, ppvi-xv).

The evaluation further highlighted a number of organisational factors critical to the success of IHSHY Projects:

- stable management and sound management/leadership/supervisory practices
- openness to change and flexible approaches to service delivery
- supportive and committed host organisation (including Board and CEO) for the program
- sense of collaboration and team spirit
- formative evaluation style
- commitment to evaluateand document findings for future learning.

Worker support

Worker support was emphasised as critical to the success of the projects evaluated (Success Works, 1997). Staff members benefit both from direct and indirect support. This may take different forms including management support of the program and its importance, professional supervision (internal or external), access to consultation with other relevant stakeholders and development of an organisational climate that welcomes and values staff recommendations about service improvement.

The *Homeless Agencies Resource Project* (HARP) was one IHSHY initiative where worker support was very important to effective implementation, as well as ensuring staff satisfaction and continuity. It operated from Child and Adolescent Mental Health Services across three Melbourne metropolitan regions. The project aimed to resource youth workers to better assess and assist homeless young people with mental health problems through liaison, consultation and education and training. The underlying values focused on collaboration and building trust between sectors with a long history of mistrust. The project also impacted on the host services by disseminating valuable feedback about the needs of homeless young people and the service re-orientation needed to accommodate their needs.

In the western metropolitan HARP project, initially based at the Royal Children's Hospital and later at Western Hospital, worker support emerged as a theme both for project workers and the youth workers they were resourcing. The project initially commenced without strong support mechanisms in place and was suspended for six months after the initial worker resigned. When it recommenced, support for the project and the worker was included as a priority issue through management endorsement and clinical and management supervision, as well as through a reference group chaired by the clinical director of the service. The final evaluation of this project (Wave Hill, 1997) identified it as making a significant contribution to service re-orientation, as well as providing a highly valued service to youth homelessness services.

The HARP evaluation also identified issues to be considered by the mental health services hosting the project. Many services do not have formal protocols regarding supervision or debriefing (except debriefing about reportable incidents). This is a key issue for staff wellbeing as there is often a gap and lack of clarity between what is regarded as reportable to the organisation and what has a serious emotional impact on the worker.

Clinical supervision, mental health consultation and staff wellbeing

In mental health services, supervision is often managed within disciplines with varying degrees of priority. Supervision may be offered by team leaders, however its occurrence and value vary greatly depending on factors such as personality, level of trust and management reporting arrangements. Staff members in specialist services tend to operate from an expectation they should have the expertise to manage difficult situations with clients and to acknowledge the difficulties and stress in their work is an admission of failure.

Clearly, the practices of professional supervision and consultation can become confused and create misunderstandings among workers. In professional counselling services, there is a clear distinction between management and clinical supervision. Management perspective supervision addresses accountability and performance issues, while good clinical supervision focuses on the professional's response to the client - providing a space for creative reflection, debriefing and clarifying personal versus professional boundaries. While some managers and team leaders, or discipline seniors, generally combine both activities, it requires a high level of skills to do so without compromising the trust and safety of the supervisory relationship, particularly where there are performance or accountability issues to be addressed.

Consultation is a key method of service delivery in Victorian Child and Adolescent Mental Health Services, reportedly impacting on service reorientaion and staff development as well as facilitating access to services for young people. The concept of mental health consultation poses even greater confusion than clinical supervision, as Luntz (1999) has acknowledged. Three components have been identified by Luntz as comprising mental health consultation:

1. a specialised professional (the consultant);
2. agency employees (the consultees);
3. and their work-related concerns – or in the case of clients, service-related concerns.

Other factors discussed by Luntz include notions of a joint exploration between the parties that values the importance of a trusting relationship and acknowledges parties with differing but equal skills. An important distinction between consultation and supervision is that the latter is an unequal relationship where there are different levels of skill. Another important distinction is that advice given in a consultation may be freely accepted or rejected by the consultee who takes full responsibility for outcomes.

IHSHY projects have also made significant inroads into changing the practice of workers in other agencies in the service network including health, youth and family services through providing education, consultation and liaison.

Reflecting this, the evaluation identified consistent reports from workers that the IHSHY projects had contributed to an improvement in their professional and clinical practice with homeless and at risk young people through opportunities for networking and training.

Staff wellbeing – worker perspectives across sectors

The Dealing with Depression Report 2001

The question of the role of worker support surfaced recently as a key theme in the *Dealing with Depression Report* undertaken by the North East Mental Health Promotion Network (2001). This network, based in metropolitan Melbourne, comprises mental health, primary health care and welfare professionals. The report discusses research (conducted by the group) that explored the experiences and challenges confronted by primary care and mental health service providers when addressing the issue of depression. The information was gathered through a series of focus groups with staff from network organisations. These included local government, community health, mental health, non-government family services, Migrant Resource Centre and Psychiatric Disability Support. Participants were asked about the following issues:

- their understanding of depression
- causation and treatment of depression
- good practice and gaps across the continuum of care

- their organisation's role in addressing depression and in supporting staff
- degree of participation in inter-agency collaboration.

There was a strong response across the *Dealing with Depression* focus groups to the question about the organisation's role in supporting staff. Support from a range of areas within the organisation was seen as necessary to facilitate work with depressed clients. Participants commented that most support and debriefing occurs at an informal level among peers, although some experienced support through team structures and internal or external supervision. Examples of participants' comments include:

> *Many staff seek external supervision as a way of preserving themselves*
>
> *Acknowledgement from peers and colleagues that you're doing a good job ... we don't say it, only to find out when you're leaving that you're OK* .

Factors challenging wellbeing by triggering stress and reducing job satisfaction included unmanageable workloads, lack of acknowledgement and appreciation from management, and poor physical work environment.

Participants also identified important protective roles for management in mediating the impact of organisational issues on workers and enhancing the experience of teamwork. The impact of culture and environment on staff wellbeing and job satisfaction was a strong theme, as exemplified in the following comments:

> *Management taking more interest in staff looking after themselves, e.g. encouraging a healthy workplace culture ... taking lunch breaks, taking walks at lunch time...*
>
> *We are not working together at an organisational level; having a voice, openness and empowerment are not encouraged.*

Recommendations of the report gave priority to staff wellbeing for all primary care and mental health services through the establishment of structures for supervision and peer support, and the development of organisational and managerial mechanisms for debriefing and support for all staff in relation to critical incidents.

Conclusion

Staff wellbeing has emerged as a significant success factor from this brief exploration of mental health promotion initiatives within both the health and education sectors. This holds true not only for the success of organisational development strategies, but also in terms of benefits delivered to those receiving services from the programs. Hopefully this evidence about the value of promoting staff wellbeing as a catalyst and facilitator of organisational development will encourage new program developers to include it as a key component of their planning.

Several common themes about fundamental success factors have recurred in evaluations of the projects described here. These invariably included a strong commitment from the leadership and a capacity to address staff wellbeing as part of the process of developing a holistic organisational approach. Nevertheless, tellingly, the observations of an earlier HARP evaluation (Boscutti, 1995) are still pertinent today:

> ...the reality and inevitability of a personal *[worker]* response to clients has been acknowledged.... However there still seems to be an unspoken expectation within some mental health circles that competent clinicians should be able to manage on their own the personal impact of their professional client relationships (Boscutti, 1995, p68).

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25 The Body Shop: bringing meaning to work

Barrie Thomas and John Murphy

The Body Shop employs more than 1200 employees in Australia and New Zealand. Part of its mission statement asserts the company will 'balance creatively the financial and human needs of our stakeholders – employees, franchisees, customers and suppliers'. The Body Shop is lauded regularly as a good model of a responsible business, especially in relation to its concern with human rights, the environment and issues to do with social justice. This chapter outlines how The Body Shop attempts, and sometimes struggles, to balance company needs with those of its employees.

Introduction

We were searching for employees, but people turned up instead

(Anita Roddick, 2000, p53)

The attitude of The Body Shop towards employees and their wellbeing is based on the company's belief that it needs to balance creatively the financial and human needs of all its stakeholders. That is, those who are affected by the company's activities – employees, franchisees, customers, suppliers, communities, animals and the environment.

Anita Roddick, founder of The Body Shop, is a strong advocate for the stakeholder approach to business and acknowledges the interconnectedness of employees' work with other areas of their lives. She maintains the company should facilitate employees' achievement of 'personal balance', which entails allowing them to be themselves, to debate the issues and to 'bring their heart to work' (Roddick, 1997, pvii). Balancing company and employee needs remains an ongoing challenge.

What is The Body Shop?

The Body Shop is a global business that sells body care products, with franchisees trading from more than 1500 retail outlets in 47 countries.

Anita Roddick opened the first store in the English seaside town of Brighton in 1976. The first international franchise store opened in Belgium in 1978. Barrie Thomas and Graeme Wise obtained The Body Shop franchise for Australia in 1983 and opened their first store in Melbourne. In 1989, Barrie and Graeme commenced a partnership with Ashleigh and Michael Ogilvie-Lee in New Zealand. There are now 70 stores throughout Australia and 17 in New Zealand.

In 1999, Barrie sold his shares in the Australian franchise of The Body Shop so he could concentrate more on his interests in the New Zealand franchise. The Australian company is now owned solely by Graeme Wise, with Barrie Thomas and the Ogilvie-Lees owning the New Zealand company.

Stakeholder approach

The Body Shop's employee practices are based on a stakeholder approach to business. Central to this approach is the belief that the long-term value of a business rests primarily on the knowledge, abilities and commitment of its employees and its relationships with investors, customers, suppliers and the local community where the company is based and trades. The stakeholder approach maintains the development of loyal, inclusive stakeholder relationships will become one of the most important determinants of commercial viability and business success (Wheeler & Sillanpaa, 1997, pix). It is a dramatic departure from the traditional shareholder approach that asserts a business has no social obligations other than financial ones to its shareholders (Friedman, 1970, p24). How The Body Shop interprets the stakeholder approach is reflected in its mission statement (Box 1).

Profile of employees

Around 90% of The Body Shop's employees in Australia and New Zealand are female. Two-thirds are under 30 years of age. Just under half are married or co-habitating, and 13% have children under 12 years of age. Forty-three per cent of employees have post-secondary school qualifications and 30% are studying for post-secondary school qualifications. Just over three-quarters of all Body Shop employees work in the stores. Around 50% are full-time, 20% part-time casuals and 30% regular casuals. Eighty per cent originate from English-speaking backgrounds (The New Bottom Line, 2000).

Box 1

Mission statement

To dedicate our business to the pursuit of social and environmental change.

To balance creatively the financial and human needs of our stakeholders: employees, franchisees, customers and suppliers.

To ensure courageously that our business is ecologically sustainable, meeting the needs of the present without compromising the future.

To contribute meaningfully to local, national and international communities in which we trade, by adopting a code of conduct which ensures care, honesty, fairness and respect.

To campaign passionately for the protection of the environment, human rights and civil rights, and against animal testing within the cosmetics and toiletries industry.

To work tirelessly to narrow the gap between principle and practice, while making fun, passion and care part of our daily life.

Campaigning for human rights and the environment

The Body Shop's practice of using its shops, and particularly the shop windows, as campaign vehicles on issues of human rights or environmental concerns has added greater meaning to the lives of employees. Originally conceived as a way of raising public awareness about issues such as acid rain, human rights abuses or deforestation, it soon became apparent that these campaigns had an additional benefit for employees.

The Body Shop tends to attract employees who embrace the social values of the company. Being involved in the company's human rights and environmental campaigns allows employees to pursue issues about which they are passionate also. Not only does this increase the congruency between their personal goals and the company's goals, which results in higher job satisfaction, but it is a positive influence on their overall life satisfaction (Murphy, 1992, p25)

Work and family

Accessible childcare for working parents is an issue often causing difficulties for families. When planning its new head office, The Body Shop Australia included a registered childcare centre on site, accessible to employees and the local community. The centre included a facility for the company's working parents whose school-age children were unwell. It enabled parents to keep working if they wanted to and to care for their children at the workplace.

The Body Shop in Australia and New Zealand strives to assist employees maintain the balance between their work and family lives. The majority of employees are female and many have young families. The company has acknowledged the pressures on working parents when their children are ill, and so have encouraged employees to use their sick leave to look after their children (and other dependents) who are unwell.

Personal development

The Body Shop employees are encouraged to take advantage of the LOVE program. LOVE is an acronym for Learning is Of Value to Everyone. Each year every employee can select an external training course they wish to undertake and that will be paid for by the company. The company's only stipulation is that the course they choose must not be related to their work. Over the years employees have studied subjects as diverse as dancing, tarot card reading, massage, lead-lighting and car maintenance.

Active citizenship

At The Body Shop, employees are provided with opportunities to engage in 'active citizenship'. Employees at each location of the company select a community group and for a few hours each week or fortnight they help the group as volunteers – in company time. Employees' actual choice of community group is not important and involvement is not compulsory. What is important, however, is that employees have the opportunity to get involved with their community. Employees of The Body Shop around Australia and New Zealand work with organisations such as nursing homes, schools, disability services, animal shelters, hospitals, guide dog training, zoos and environment groups. For employees, The Body Shop's community volunteering program:

- Improves their existing abilities and teaches new skills
- Broadens their outlook through providing work experiences outside the company and their usual field of work
- Introduces them to active citizenship
- Provides satisfaction from contributing to the community
- Increases their community support networks
- Makes work more meaningful and interesting
- Provides those who have busy personal lives (family, study, etc.) with opportunities to become involved in their communities as volunteers during working hours without loss of wages.

The community benefits by having additional volunteers and The Body

Shop gains in a number of ways, not least of which is having a more motivated and satisfied workforce. The volunteer activities of employees help the company fulfil its mission objective to 'dedicate our business to the pursuit of social and environmental change'.

Employees' job satisfaction

In 1998 and 2000 The Body Shop in Australia underwent independently verified social and environmental audits (The New Bottom Line 1998, 2000). At the time of writing, the 2002 audit was in process. A social and environmental audit is a non-financial form of accounting. It measures a company's social and environmental performance against its social and environmental goals. Other terms to describe the process are ethical and ecological auditing (The New Bottom Line, 1998, p10).

Underpinning social and environmental auditing is the belief that the role of business in society is more than just about making profits for shareholders. Business also has a responsibility to ensure the wellbeing of the people, communities and environment most affected by its activities. Social and environmental reporting is becoming more common overseas, but has not been accepted widely yet in Australia. The Body Shop was the first company in Australia and New Zealand to undergo an independently verified social and environmental audit (The New Bottom Line, 1998, p3).

Social and environmental auditing is a way of ensuring The Body Shop remains committed to its mission, and provides a framework for the company to improve its performance in these areas. The company in Australia has undertaken to have a social and environmental audit every two years. The company's social audits included an examination of the internal culture of The Body Shop – its relationships with its employees and their attitudes to the company's values, vision and practices. For the 2000 social audit, 734 survey forms were distributed to employees. They were asked to respond to various aspects of their work at The Body Shop. Eighty-three per cent (N=602) responded. Responses were self-administered and anonymous. The following is a small sample of the results of the staff survey.

ITEM	% AGREEMENT
I am proud to tell others I am part of The Body Shop	96
The Body Shop takes steps to balance the needs of its employees, customers and other people impacted by the company	86
Working for people I respect is a very important reason why I work at The Body Shop	98
Good relationships with co-workers is a very good reason for working at The Body Shop	99
I trust The Body Shop to ensure that their employees are paid fair wages	78
Most days I am enthusiastic about my job	89
The Body Shop's business practices reflect a high standard of ethics	92
My job is secure at The Body Shop	81
Training opportunities at The Body Shop are very good	81

While these responses are overwhelmingly positive, they were not included here simply because they show the company in a good light. They are representative of the majority of employees' responses to most of the other items in the survey. The survey's findings suggest that overall, work at The Body Shop is a positive experience for most employees.

The company is not perfect

Often The Body Shop is put on a pedestal as a model of business social responsibility, but the social audits of 1998 and 2000 reveal the company is not perfect. Not all employees were entirely happy with every aspect of their work at the company.

Overall, only a small proportion of the company's employees indicated dissatisfaction with various aspects of their work. They included autocratic decision-making within the company; pay rates not reflecting the responsibilities of positions; employees' skills not being utilised to the fullest; job security; and inconsistency of behavior and decision-making of supervisors.

There were two items in the employee surveys, however, which brought a higher proportion of negative responses. They relate to The Body Shop's values and vision. The Body Shop's charter states:

> The Body Shop goals and values are as important as our products and our profits.

The 1998 and 2000 social audits revealed increasing numbers of employees believe The Body Shop's original values and vision are being eroded as the company in Australia and New Zealand has experienced rapid expansion. According to the 1998 social audit (encompassing Australia and New Zealand), a quarter of employees felt The Body Shop's values and vision had been lost, and a third felt the company's values and vision took second place to sales. The 2000 social audit (involving Australia only) revealed the number of employees who believed The Body Shop's core values and vision took second place to sales had grown to more than half (55 %) –an increase of 22% in two years. This increase is even more significant considering that after the 1998 social audit the company set a target of reducing by 15% employees' negative perceptions about The Body Shop's values and vision. Despite the company's efforts, employees' negative perceptions increased.

The values and vision of The Body Shop are an integral component of its position as a socially responsible business and, as indicated earlier, it tends to attract employees who embrace the same social and environmental values as the company. Employees, in turn, promote enthusiastically these values to customers and the wider community, which enhances the effectiveness of The Body Shop's campaigning.

Recently Anita Roddick reflected on the company's early attitude to its employees as:

> ...valued, respected, fuzzy and cuddly, nerdy as that sounds. We understood life was no more complicated than love and work. (2000, p57)

Realistically, it would be difficult to sustain a caring, small-company soul in a rapidly expanding international corporation where the franchisees' interpretation of the The Body Shop's values and vision is as diverse as the cultures of the nearly 50 countries in which the company operates.

In its charter The Body Shop still refers to employees as part of the company's 'family'. It is likely, however, as the company has expanded, The Body Shop in Australia and New Zealand has become less like a family and more like a corporate bureaucracy (albeit a relatively small one) with increasing layers of management personnel separating front-line employees from the head franchisee/s.

Often a company's values and vision statements are there mainly for marketing and public relations rather than genuine application. Organisations such as The Body Shop maintain values and visions that are intended for practice. To ensure this happens, there needs to be strong promotion of the company's visions and values among employees via the company's leadership and through exemplary conduct by the company.

When organisations such as The Body Shop promote their virtuous aims publicly, inevitably their performance will be subjected to much greater public and stakeholder scrutiny. Therefore, when The Body Shop states categorically it will balance the financial and human needs of its stakeholders, and then fails or appears to fail to achieve this, it is likely to be judged more severely than other companies maintaining lesser standards.

Perhaps the best recent example of a major discrepancy between The Body Shop's core values and its business practice was when the company in England significantly downsized during the late1990s, with hundreds of employees made redundant. Despite appearing to handle the situation more humanely than many other companies might, it was not a good example of The Body Shop balancing the needs of the company with those of employees.

Clearly, the expansion of the company has been about increasing opportunities for greater profits. Employee redundancies in Australia (The New Bottom Line, 2000) and in England have been about maintaining financial efficiency. Management restructuring has been about organisational efficiency in anticipation of greater financial efficiency. When coupled with the emergence of a less-personal ambience within the company resulting from its rapid expansion, it is understandable why employees have begun to question the company's original values.

As The Body Shop continues to expand in Australia and New Zealand, it will be difficult for the company to continue to claim with credibility that its goals and values are equally as important as its products and its profits.

Another likely contributor to employees' concerns about erosion of the company's values is Anita Roddick's decreasing role and influence within the company. It is clear from her prolific writings and media appearances that she still maintains the same fundamental values upon which she founded The Body Shop. Through personal choice, however, she has reduced her hands-on management role within the company.

Nowadays, much of the direction of The Body Shop International is determined by corporate high flyers recruited for their management prowess rather than for their affinity with the company's core values.

Anita Roddick has been a strong promoter of The Body Shop's values and vision both within and outside the company. Her charismatic and inspirational leadership with employees, especially female employees (90% of The Body Shop's employees), has contributed in a major way to sustaining The Body Shop's values and vision and the enthusiasm of employees for their work at the company.

If erosion of The Body Shop's core values continues in the way that employees believe it has, it is likely over time that fewer employees with values compatible with the original values of the company will be attracted to work there. Current employees whose values are strongly congruent with the company's original values will become increasingly disillusioned as the gap between their own and those of the company widen. The company in Australia and New Zealand boasts a lower employee turnover rate than the retail norm. However, continued loss of the company's core values and vision eventually may bring The Body Shop's employee turnover rate back to the norm.

After the 1998 social audit, 17 targets were publicly documented for increasing the satisfaction of stakeholders by 2000. Five targets were met; progress was made towards achieving another eight; and the company failed to meet four of the targets – the most prominent of which involved reducing employees' negative perceptions about the company's values and vision.

Conclusion

Despite some of the issues raised above, it is clear that for most employees at The Body Shop in Australia and in New Zealand, their work is a very positive experience. Contemporary businesses where such a high proportion of employees report being satisfied with so many important aspects of their jobs are not in abundance.

It is clear also that as The Body Shop has been growing, it has been difficult for the company to maintain its original values alongside its changing business practices. Employees have questioned The Body Shop's assertion that its goals and values are as important as its products and its profits. Of all the company's stakeholders, employees are probably the best placed to pass judgement on its performance in this area. It will be interesting to see if the 2002 social audit reveals that employees' negative perceptions about The Body Shop's values and vision have continued to increase.

The Body Shop's commitment to public accountability is commendable. Most companies are secretive about or understate their failures and indiscretions. The Body Shop publicly acknowledges that it is not perfect and clearly has displayed a commitment to improve its performance.

The Body Shop maintains a position as one of the better role models in the area of business social and environmental responsibility. The fact that 96% of employees are proud to tell others they are part of The Body Shop is testimony to the company's achievements in this area.

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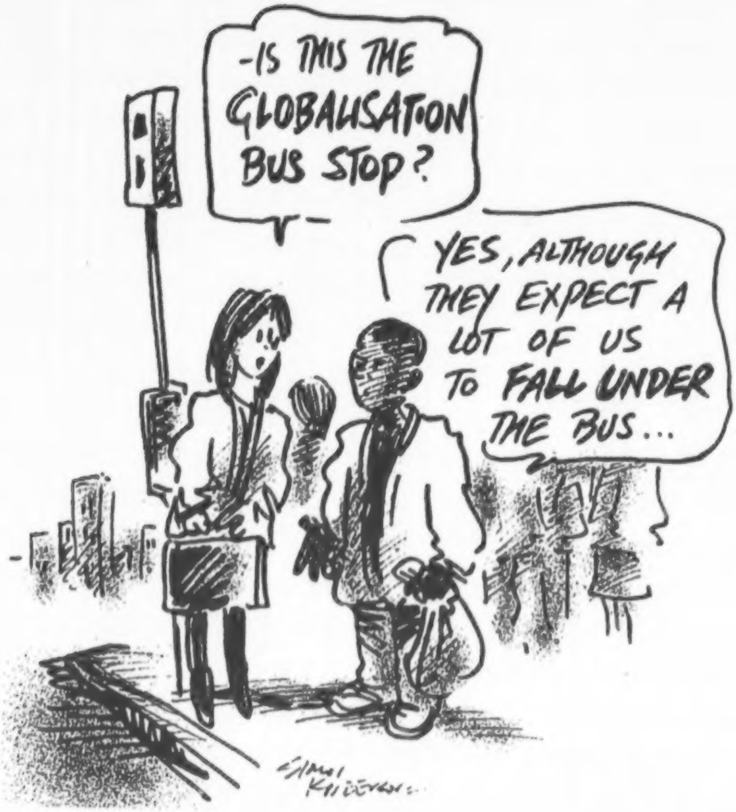
-IS THIS THE GLOBALISATION BUS STOP? -
YES, ALTHOUGH THEY EXPECT A LOT OF US TO **FALL UNDER** THE BUS...

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